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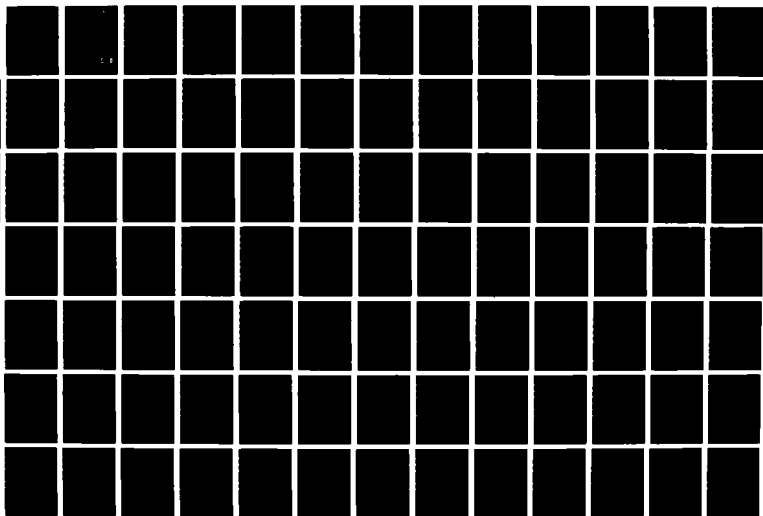
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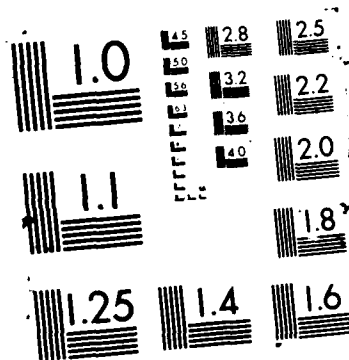
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A VISITOR CONTROL POLICY FOR
MARTIN ARMY HOSPITAL

BY
JAMES P. GINN
MAJ MSC

Problem Solving Project Submitted
in Partial Fulfillment of
the Requirements for the
Residency Year

April 5, 1978

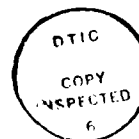
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INTRODUCTION

Background

"I tiptoed in and stood quietly by her bed for my allotted few minutes. When she opened her eyes and saw me there, her face lit up with a beautiful smile. Conscious, sane, rational, and uncomplaining, she spoke a bit with me before dozing again. She would die as she had lived, with joy. For her, one could say this. But I'll never know if she opened her eyes again and missed me, wanted me, needed me. I'll never know and it haunts me. For in that superb medical facility, death was evidently not considered a family concern -- only a medical problem. The comfort of the quiet presence of husband, daughter, or sister was not approved for more than five minutes. The family love of a lifetime should have surrounded her last few hours of life, a comfort to her and her family."

My mother was 80 years old when she died, and she died without any of her family near her. The rules said no. Nurses and large signs stated clearly that five minutes were allowed for visitors. The strange part was that we -- her family -- did not feel like 'visitors'. We were a part of her."

The preceding quotation did not take place at Martin Army Hospital although it did actually happen. The paragraphs that follow reveal incidents that did occur at Martin Army Hospital. They have been taken from the Administrative Officer of the Day's report from January 1977 through October 1977.

A patient arrives at Martin Army Hospital's emergency room suffering from a gunshot wound of the head. The wound is a result of a shooting incident in the man's office where he was shot by his wife. Immediate transfer to the Medical Center was made due to lack of neurosurgery capability. After surgery and stabilization, the soldier is returned to

Martin Army Hospital for further treatment and disposition. A call is received that the soldier's life is still in danger as the wife now allegedly has a contract out on him to finish the job. Guards must be posted at his door 24 hours a day.

At 0540 hours on 15 January 1977, Ward A-2 reported finding a male adolescent wandering around near their area. The Administrative Officer of the Day (AOD) made a search of the area but was unable to find the individual. One hour later, the AOD again received a report from Ward A-2 on the same individual. The military police were called and aided in the search but the individual could still not be found.

At 0030 hours on 23 January 1977, the Staff Duty Noncommissioned Officer (SDNCO) reported finding a male individual on the Ward A-6 waiting room. Upon questioning, the person stated he was waiting for his mother to come pick him up. The military police were notified and the individual was released to them for disposition.

At 2230 hours on 6 March 1977, an unidentified male was found in the snack bar. The individual was brought to the Information Desk where he was questioned. He refused to answer any questions and had no identification on him. He was escorted from the building.

On 20 March 1977, an individual was reported and observed wandering on the first floor of the facility and around the hospital grounds. The military police were notified and apprehended the individual at 1600 hours.

On 21 May 1977, Ward A-6 reported to the AOD that a fight had broken out on the ward. The fight was between a husband, who was the patient, and the wife as well as the girl friend who arrived at the same time to visit. Assistance from the military police was requested and the situation was resolved.

On 31 July 1977, Ward B-7 found a dependent wife hiding on their ward from her husband. Neither the wife nor the husband were patients in the facility, but were using it as their battleground. The military police apprehended and escorted the couple to the local police department.

In October 1977, a 17 year old mentally retarded dependent female was found wandering in the hospital sometime after 2400 hours. Identification was made and the dependent released appropriately.

There have been numerous reports of car thefts and vandalism in the hospital parking lots. Also not uncommon is the report of money or valuables being stolen from the wards and other areas of the hospital. Space does not permit each such incident to be depicted, and those given are presented only to indicate the nature of the problem that exists.

The question to be asked at this point, is why do they happen. The answer would appear to be fairly obvious for anyone familiar with the operation of Martin Army Hospital. There is, for all practical purposes, no control over the visitors to the facility. An analysis of each incident reveals that this "visitor," in one form or another, is a common entity in each. No one knows how many visitors come in or go out of the facility,

or how many are on the ward or in the hospital at any one time, or even how many visitors a patient has crowding his/her bedside during any part of the day.

Certainly there are visitor regulations, but unless the nursing staff on the ward enforces the policy, it does not get enforced. This requirement is virtually impossible to perform when we consider the many nursing duties that must be accomplished.

To a lesser extent is the problem of the visiting clergy or business representative who wanders about the facility doing their job, usually with good intentions, but uncontrolled.

The announcement of the end of visiting hours being over is currently up to the individual area to make and enforce. The response depends upon the individual visitor and the time of the nursing staff to enforce their directive.

Even the visitor themselves are presented with a problem of who do they go to for questions or problems of visiting patients. Uncontrolled access puts the visitor in touch with many different people who have potentially as many different answers. This creates confusion and frustration for the visitor and bad public relations for the hospital.

There are 28 entrances and exits to this facility that, as stated, provide uncontrolled flow in and out. Equipment as well as medical

supplies transported from the hospital illegally through these doors, although largely unsubstantiated, is estimated as significant.

Alluded in the preceding paragraph is that the design of the facility is itself part of the visitor control problem. There is a central rectangular core with wings extending from each side. Two of these wings have nine floors and contain by far the majority of inpatient beds. The other two wings extend only partially up the core and contain the ancillary departments, outpatient clinics, and the administrative areas. Figures 1 and 2 provide a top view and a side view respectively.

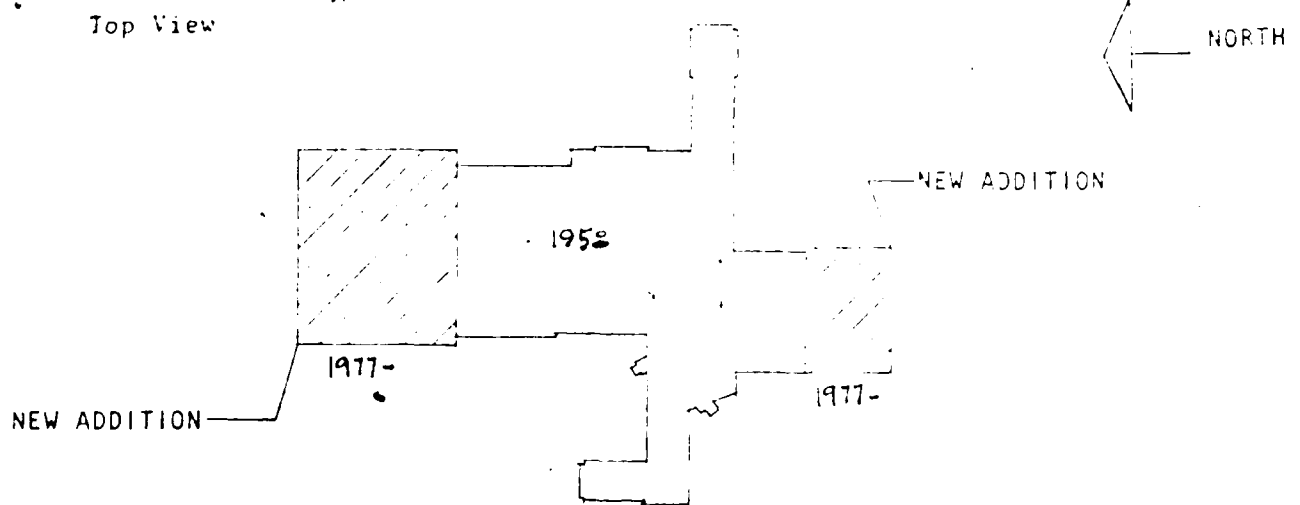


Figure 1. Top View

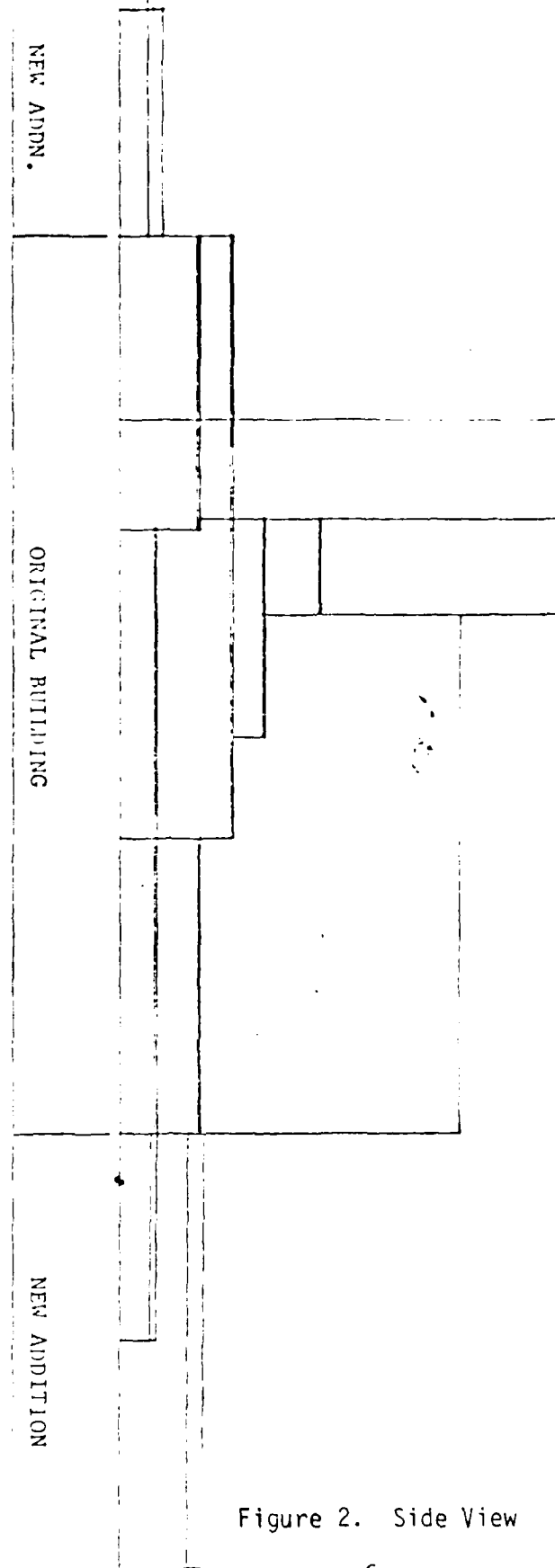


Figure 2. Side View

There are three major or planned entrances as shown on Figure 1, the clinic wing, the emergency, and the main entrance. The new clinic wing entrance is closed due to construction and is expected to remain closed until later 1979. Of the two remaining entrances, the emergency entrance is in more of a direct path from the main parking lots to the facility, and thus draws a large number of users who utilize it simply as an entrance to the rest of the hospital.

The background of the problem should now be apparent. With the exception of the introductory quote, all situations depicted are actual occurrences at Martin Army Hospital as earlier stated. Given the current policy, the potential exists for almost anything to happen, including a recurrence of the first tragic note presented. The purpose of this study is to attack the visitor, and the problems as well as the benefits they present. Attack, of course, is not meant in the physical sense nor is it an indication that the visitor is considered an enemy.

Statement of the Problem

To design a visitor control policy for Martin Army Hospital, Fort Benning, Georgia.

Definitions

The following definitions apply:

(1) Visitor: Any individual entering Martin Army Hospital not employed by the facility or whose name does not exist on the Table of Distribution and Allowances of the Medical Activity, or the Dental

Activity -- not entering for the purpose of conducting official business.

A visitor may be classified into one of several categories.

(a) Outpatient: Any individual entering Martin Army Hospital for the purpose of securing medical care, treatment, or advice on an outpatient basis.

(b) Inpatient: Any individual entering Martin Army Hospital for the purpose of receiving medical care, treatment, or advice on an inpatient basis.

(c) Patient Visitor: Any individual entering Martin Army Hospital for the purpose of visiting an inpatient of that facility.

(d) Official Visitor: Any individual entering Martin Army Hospital for the purpose of conducting the official business of their office. This includes local, state, federal, and military officials acting in the capacity of their office.

(2) Staff: Any individual military or civilian employed by Martin Army Hospital or whose name appears on the Table of Distribution and Allowances of the Medical Activity or the Dental Activity.

(3) Visitor Control: Any action taken to restrict the movement of visitors within the facility, any action taken that restricts access to the facility by visitors, and any action taken that places time limits on the presence of visitors to the facility.

Objectives

The designing of a visitor control policy requires a multitude of

intermediate tasks to be accomplished as part of the overall policy. The following list applies to this study although the order of listing does not indicate any priority of completion.

(1) Predesign of the information desk located in the lobby of the main entrance.

(2) The designing and writing of a visitor brochure for Martin Army Hospital.

(3) The design and selection of a visitor identification badge.

(4) The standardization of bed locations for each ward.

(5) The determination of the entrances that may be used by staff during other than normal duty hours as pertains to the placement of special locking devices.

(6) Selection of the locking devices for the staff entrances.

(7) Coordination of a support agreement with the military police at Fort Benning, Georgia.

(8) Survey of the attitudes of patients, both inpatients and outpatients, towards visiting and visitor control by use of a questionnaire.

(9) Analysis of the patient questionnaire to aid in policy formulation.

(10) Reduction of all information to writing as the visitor policy for Martin Army Hospital in the form of a hospital regulation.

Criteria

The criteria that will be used to evaluate and therefore judge the

effectiveness of the policy are:

- (1) A reduction in the frequency of incidents reported on the AOD report where unauthorized individuals are found within the hospital.
- (2) A reduction in the frequency of staff complaints regarding too many visitors which are inhibiting patient care.
- (3) A reduction in the frequency of patient complaints, particular in open ward areas, of too many or inconsiderate visitors.
- (4) A reduction in the frequency of thefts and vandalism within and outside Martin Army Hospital.
- (5) Feedback from patient surveys conducted by patient affairs personnel.
- (6) The number of complaints received from visitors to the facility.
- (7) The number of positive reports regarding the system from visitors to the facility.
- (8) The number of badges that are not returned by patients.

Limitations

The following limitations have a bearing on the study.

- (1) Hiring limitations prevent consideration of a security force as part of the policy.
- (2) The design of the facility is itself a limitation in the sense that the effectiveness of the solution is tempered to some extent because of the design.

Assumptions

The following assumptions were made:

- (1) That funds will be made available to accomplish the renovation of the information desk.
- (2) That funds will be made available to procure the visitor identification badges.
- (3) That authorization to hire any additional personnel required will be granted and funded.

Literature Review

Paney² writes about a belief held by many that patients are in the hospital to be visited. He finds those people who would never dream of intruding upon someone ill in bed at home, and who may not have any social intercourse with the person when well, that nevertheless have the urge to visit as soon as the person is admitted to a hospital. It never occurs to them to ask the nearest relative whether the patient felt well enough or wants visitors; they arrive unannounced and unwanted, much to everyone's discomfort. Paney did feel that patients appreciate extended visiting hours that allow visitors to come who might otherwise find it impossible, but most patients preferred, other than for the next of kin, that visiting time be limited. His survey did show that patients wanted some time set aside exclusively for the next of kin.

But not security personnel??
(inconsistent)

Lee-Jan³ in studying the length of stay of patients in psychiatric hospitals quotes Weinstein on a similar study. Weinstein felt that there were two criteria for determining when a patient was to be released from the hospital: the ideal discharge criteria, which are essentially psychological in nature, and the real discharge criteria, which consist essentially of social and environmental factors. Among these social and environmental factors, Weinstein measured the most important seemed to be those related to patient families. Lee-Jan, in analyzing Weinstein's results and others, established that families concern does have an impact on the length of hospitalization. The major finding being that the more frequently mental patients are visited by relatives or are taken home for a leave of absence, the shorter will be the stay in the hospital. He does not say of these two variables, which is the more important.

McKeown, Cross, and Keating⁴ who studied the influence of hospital siting on patient visiting can easily be tied together with Weinstein and Lee-Jan's study of psychiatric patients. The McKeown, Cross, and Keating endeavor was focused on geriatric, psychiatric, and mentally subnormal patients who had extended length of stays. As part of their findings was the comment that the distance the hospital was located away from the patient's origin was directly related to the frequency of the patient's visitors. It would be valid here to state that if the desire was to reduce the length of stay of those patients studied, consideration must be given

to improving the frequency of patient visiting through relocation of patients close to home or improved transportation for the visitor to the facility.

Cross in a later study with Turner⁵ supported his earlier attempt. The findings were basically identical to his earlier work, with the additional note that for a person to be classified as a long term or short term patient, there was a relationship between not only distance but the frequency of visits. Cross himself is making the tie-in suggested in the earlier paragraph.

Tampe, Trause, and Kennell⁶ found, as might be expected, a tremendous disruptive effect on families and children who were hospitalized immediately upon birth. If these children, they said, could have gone home for a short time or if live-in facilities were available at the facility, this disruptive effect might be minimized. This was based on the finding that mothers and fathers who got to know their child through parental contact had a much higher visiting frequency and adaptation ability than those parents whose children were taken from them immediately, and placed in the neonatal unit. Parents who had some time alone with the child accepted the situation better and an obvious positive effect on the child can be predicted by referring to earlier studies on length of stay and the frequency of visits.

Harper, Sia, Sohal, and Sohal⁷ accomplished a similar study as Lampe regarding pediatric patients. Where the quality and quantity of parental

contact can be determined by the parents, they observed, a high level of contact will occur. These observations are based on a neonatal intensive care unit with unrestricted visiting privileges for the parents. Clergy and parents were eager to visit and become involved with their infants, but the emotional involvement can become overpowering. The parents found frightening things that were to the physician reassuring, such as the technology and machines being used. To this extent many felt their presence necessary for the emotional and physical well being of their child, believing that their presence brought about an improvement in the quality and quantity of care. This last comment reeks of bad vibrations if the connotation is that unless someone is watching over the shoulder of hospital staff, the patients will receive less than optimum care. Parents, even at the death of their child, were found not to regret the amount of time spent with their infant. A survey in the study revealed that 82 percent would have opposed restricted visiting hours and 90 percent would have resented restricted contact with their infants. Parental infant contact in the Intensive Care Unit was felt to be a good idea despite the correlation of rising levels of anxiety associated with increased infant morbidity, increased infant contact, and the impact of the intensive care nursery environment. The study concludes that new policies for the care of parents of infants in neonatal intensive care units should be developed in order to help parents constructively

manage their anxiety, since this may be an important aspect in the acceptance of their infants. It does not seem too far a transition to apply this conclusion to the adult patient.

Speck⁸ writes that visiting is of special importance as it bridges the gap between the sick person, the hospital and the community. He felt that hospital staff must be aware of the visitor's problems that may not be so obvious such as lack of transportation, babysitting, the visitor's own sickness, and so on. These not so apparent problems, he calls communications, fear, and feelings of inadequacy. Communications problems arise where the patient may be unable to talk to the visitor because of surgery or medical treatment being rendered. Fear on the part of the visitor may be encountered if the visitor sees his own self as becoming ill or even facing death. This may be especially true if the patient is surrounded and connected to tubes, bottles, and machines in the treatment of their illness. Feelings of inadequacy are more apt to be felt by the next of kin visitor who previously had taken care of the patient at home, and now since hospitalization is placed in a position of an observer not knowing what to do or being allowed to do nothing.

Neal and Cooper⁹ commenting on the problems nurses face on intensive care units, find that flexibility and a little ingenuity can often make the difference between happy and unhappy relations with the people you are there to serve -- the patients. Sometimes bending the rules on

patient visiting enhances patient care and a successful outcome.

Kimella¹⁰ feels that we all too often ignore, reject, or at best underestimate the importance of an integral part of the complete health team -- the patient's relative. Family counseling for parents in the care of children seems natural; yet family counseling in the care of parents by their children which should be every bit as natural is many times not thought of.

Gordon and Hallauer¹¹ reported positive results on their study of the attitudes of college students toward the aged, while participating in a visiting program as part of a course on adult development. These positive results were for both the aged person and the student. At the end of the test period, the researchers found that 80 percent of the students wanted to continue with the involvement, with one student commenting that at first he was only a visitor, now he was a friend. This may be carrying acute care hospital visiting to the extreme, but the application for extended care facilities or long term patients is possible. The important point of the entire study is not only that again we find that visiting is positive toward the patient, but here we find that the visitor benefits as well.

Horty¹² writing on health care law cautions the hospitals with construction programs. Since today this involves almost all facilities in one way or another, his words should be heeded. He states that when construction takes place, it is important that it be clear that the construction company has the responsibility to be sure that the construction site is walled off from the general public, and policed since people

will continue to come routinely to the hospital premises. This understanding should be in writing. Further, the hospital must be certain that the construction company cleans up all debris and that the company is amply insured.

Grady¹³ also writing on health care law draws a parallel between a case where visitors were encouraged to view an exhibit resulting in a fall and subsequent law suit, and the hospital visitor. The basic law concerning the invitee or visitor is that the visitor using reasonable care on their part for their own safety, is entitled to expect that the occupier (hospital) on its part shall use reasonable care to prevent damages from any unusual danger it knew or should have known was present. When we apply the preceding fact that visiting improves patient care and subsequently encourage visiting within the hospital, we must also insure that we meet the basic requirements of the law.

Rozonsky¹⁴ in reviewing Canadian Negligence Law finds that as the law applies to hospitals and their visitors, it is the most confused area of all. Canadian law defines hospital visitors as either invitees, licensee, or trespassers. The liability of the hospital depends upon status the individual visitor was in at the time of the injury -- this status to be determined by the hospital's solicitor. The invitee is generally described as one who enters the premises pursuant to a business interest which concerns the occupier (the hospital). This category of

visitor receives the greatest protection under Canadian law. Next in line is the licensee who does not share an interest with the occupier as to his presence on the land but whose presence is lawful. Lastly, is the trespasser who has no permission to enter. Visitors in Canadian hospitals have traditionally been classified as invitees since they share with the hospital an interest in the well being of the patient, and the hospital has an interest in the visitor who can assist in the health care of the patient. The question that naturally rises from this information is, could some hospitals, operating with manpower shortages gain assistance from designing an innovative visiting program.

Many churches consider the visiting of patients in hospitals, particular members of their own congregation, as a duty that must be carried out. To this extent, Wright¹⁵ teaches the lay person how to visit so as to make the most out of the effort. A visitor education program is only a step away from the education of the church member who visits and maybe a step in the right direction. Ample methods through the media and committees already exist for such a program. Wright advocates that instructions to visitors should be positive. A visitor should not receive a list of "Don't" but instead receive positive input. Example: Rather than saying, "don't stay forever," say "a visit of five to ten minutes is often long enough." Keep the instructions simple. Visitors could be provided with a list of things to do before getting

to the hospital, before getting to the patient's room, before entering the room, after entering the room, upon leaving the room, and after leaving the room, to make the visits much more enjoyable for both.

Morrison¹⁶ studying a visitor control program in an Atlantic City Hospital relates that improved security and visitor control have stopped employee complaints about their belongings being stolen from locker rooms; decreased patient thefts to a minimum; restricted visitors to the patient floors thus giving the employees less interference during the working day; received praise from physicians because fewer visitors are in rooms while they are attending patients; stopped visitors from wandering freely throughout the hospital; and reduced pilferage from the hospital.

Statistics gathered at York Hospital resulted in the limitation of two visitors per patient at one time. This was not an arbitrary decision by management but resulted from comments from patients. Patients felt that they were at the mercy of anyone who walked into the room. Few patients will take the chance of offending a visitor by asking them to leave even though they are physically uncomfortable and fatigued.

Simmons¹⁸ cites a security system in effect at many southern hospitals for the goodwill, respect, and support each hospital receives in its own community. Patients, along with their friends and relatives, continually express their appreciation for the care exercised, and the concern for

the individual safety shown during periods of hospitalization and convalescence. The benefits that are seen as part of this system were as follows:

- (1) Precise control over the number of persons admitted during regular visiting hours.
- (2) Elimination of intrusions by outsiders and prevention of unauthorized entries into restricted areas.
- (3) Implementation of special security precautions at separate entrances for doctors, nurses, administrative staff and hospital employees.
- (4) Ready identification for persons visiting the hospital.
- (5) Better protection for patients who could otherwise be subjected to unwarranted and inconsiderate interruption by outsiders.

Trites and Green¹⁹ in reviewing the literature on patient visiting found few articles that provided much more than a personal opinion of the writer as to what a visiting policy should be. They state, which this writer agrees with, that before hospitals establish visiting policies, they should first determine the patients' wishes regarding visitors and examine the factors related to those wishes. Trites and Green then reported on the results of a questionnaire they presented to patients. The questionnaire that will be discussed later as a part of this study is an adaptation of their questionnaire but not nearly as complex due to limited (one person) analysis, and that being manual. Summarization of their findings follow:

(1) Patients make a sharp distinction between members of their immediate family and other visitors.

(2) There was no limit on the length of the visit or the time of day for visiting placed on family members.

(3) Friends were preferred to visit during the afternoon or evening for short periods of time.

(4) Restrictions were recommended for visitors being in the room while patients were receiving care by hospital staff.

(5) Patients would place some restriction on the number of family members visiting at one time but not necessarily at the one or two person level.

(6) Patients would not recommend more than two non-family members to be present at any one time.

(7) Family size and room accommodation may be ignored when developing visiting policies.

(8) The degree of illness of the patient may not be related to his/her preference for visiting, which leaves open for discussion the often found policy of tailoring visiting based on the degree of illness of the patient.

(9) Age is a factor that should be considered when considering length of time visitors spend with patients.

(10) The sex of the patient appeared to have a direct bearing on several aspects of visiting.

- (a) Men preferred evening visits and women preferred afternoon.
- (b) Men were slightly more liberal concerning length of visit time than women.
- (c) Women most often preferred fewer visitors than men.
- (d) Women objected to visitors during mealtime more often than men.
- (e) Women were more concerned about the presence of visitors while being attended by hospital staff than men.

Trites and Green conclude that no one visiting policy will be the correct one for all patients. The attempt should be to maximize the satisfaction of the greatest number of patients. They feel that this goal can be reached by: (1) placing controls on visits by friends, (2) matching roommates as closely as possible on the basis of age, education, distance from home, size of home community, marital status, and reason for hospitalization; (3) requiring all visitors to leave the room while a patient is being assisted by a nurse; and (4) encouraging family members to visit in small groups.

Research Methodology

The methods that were used to collect, record, and evaluate data included:

- (1) Patient interviews.
- (2) Staff interviews.

- (3) Visits to civilian medical facilities.
- (4) Telephonic contact with medical facilities.
- (5) Literature review.
- (6) Review of Martin Army Hospital documents such as Unusual Occurrence Reports, AOD and SDNCO reports, committee minutes, and others.
- (7) Distribution and analysis of a patient questionnaire on patient visiting.

DISCUSSION

The Visitor

Visitors in hospitals are often regarded by the hospital staff as something of a nuisance. It is difficult for the staff to put themselves in the position of the anxious relative, the worried husband, the harassed mother; yet unless they can gain some insight into their problems, how are they (the staff) to offer the support and understanding that these visitors often need.²⁰

The well-established social practice of visiting relatives, friends, and even casual acquaintances while they are in the hospital is perhaps most commonly viewed as a sociable, thoughtful act. It would appear, moreover, that almost every hospital patient welcomes visitors when they are sick and temporarily socially isolated from the familiar surroundings of home, family, and work. Indeed, for some patients, a high "turnover" of visitors may be counted as a testimonial to their individual popularity and esteem.²¹ The other side of the coin is whether this same feeling of welcome is extended by the hospital.

Hundreds of people are admitted to hospitals every day of the week, so for medical and nursing staff this is a routine procedure. For most patients, however, this is a once-in-a-lifetime experience of great importance. Many factors will influence

the patient's reaction and how they are affected by their stay. The aim of every health care provider is to cure the patient or, if that is impossible, to alleviate symptoms so the patient goes home able to cope with and accept their illness. Much thought has been given to visiting children in hospitals; I wonder if enough consideration is given to the visiting of adults who can also be lonely, frightened, depressed, or bored. The good visitor is able to fit in with the patient's mood so that the patient feels comfortable and relaxed during the visit and derives some positive benefit.²²

The preceding paragraphs were chosen specifically for the purpose of stating that this is not a paper against visitors. On the contrary, it will be shown throughout that the good visitor is necessary as has already been sufficiently depicted in the literature review.

Questionnaire (Appendix A)

It would have done little good to establish a visitor control policy that was against the opinions, or failed to solicit the opinions of the patients themselves. To have done so, would have doomed to failure any established policy - especially in today's times when management is required to receive input from the consumer on many management decisions. Even discounting the above, the patient was felt to be a logical place to start obtaining ideas about what policy to implement

Obviously the idea was to get opinions, but it was also to test a hypothesis that the preceptions of patients as to how they would like to be visited, would change from the time they were outpatients, until they had been in the hospital three days. Additionally, it felt that there would also be a difference in the way patients wanted to be visited by their immediate family members, other relatives, and good friends. The immediate family was considered mother, father, husband, wife, children, brother, sister, and grandparents. Other relatives were aunt, uncle, cousin, and so forth. Good friends were just that - no relation.

It was immediately recognized as impossible, within the constraints, to track any single patient through this established continuum, outpatient to inpatient of at least three days. The questionnaire was therefore given to three categories of patients - the outpatient, the patient at the time of admission, and the patient hospitalized at least three days. By analyzing the responses of each patient category surveyed against each other, a part of the hypothesis would be tested.

To test the part of the hypothesis regarding the desires of patients for visiting by certain categories of visitors, the questionnaire was divided into three sections - each section represented one of the three visitor categories established.

Each of these sections asked the identical questions, and the patient surveyed was asked, when completing each section, to only think out how they felt toward that particular visitor, excluding all others. Some carryover to other sections was inevitable, but should be minimized through this type of reinforcement.

Six hundred questionnaires were prepared and distributed. Two hundred were given to each of the three categories of patients surveyed. Outpatients returned one hundred twelve for a response rate of fifty-six percent. The admissions category of patient returned one hundred thirty-eight for a response rate of sixty-nine percent. Inpatients only returned seventy-three or thirty-seven percent. The response rate was less than expected, and is attributed to a lack of emphasis being placed on the questionnaire for its completion and return by those assisting.

Some patients were even found to only partially complete the questionnaire leaving some parts completely ignored. Further analysis revealed that this applied only to the inpatient and admissions category of patient surveyed. The rationale that the illness of the patient, or their feeling at the time the survey was administered was related to this finding, would appear as justified by assuming that these categories of patients are the sicker of the three surveyed.

eliminating questionnaire units
help patient

Question number five in each section and Section IV General, in total were eliminated because of an extremely low response rate, and the inability to manually analyze the information that was being received. Computer support would make this possible for future studies. These questions, since two of the three eliminated required the patient to write an answer rather than circle, or mark an existing response, may need to be evaluated in terms of making it easier for the patient to select an answer, and therefore a better response rate could be predicted.

Table 1 (Appendix B) provides a matrix of responses by question, patient category surveyed, and by questionnaire section. Each three by three matrix represents one possible choice as an answer for a particular question, analyzed by patient category and visitor category. For example, question number one had four choices, and therefore there are four matrix possibilities. To make these numbers more meaningful and be able to relate them to each other, they were reduced to a percentage of all responses to that particular question, by section and by patient category. This was further necessary to be able to graph the responses, as not all respondents completed each question. Illustrating this from Table 1, outpatients in responding to question number one of section one six responses for the first choice, forty-two for the second, seventeen for the third, and forty-six for the fourth

possible choice, for a total of one hundred eleven responses. Converting each response rate to a percentage of the total responses, we arrive at Table 2 (Appendix C). This table is interpreted the same as Table 1 with the numbers now representing percentages. The graphs at Appendix D and E depict a visible picture of these percentages as they relate to each other. Comments that follow each graph interpret the responses.

A summarization of the findings from the analysis of the graphs follow:

(1) Regardless of the category of patient surveyed, all preferred that visitors be limited to two at one time for any category of visitor.

(2) Each category of patient surveyed preferred that there be no limit on the length of the visiting time for the immediate family.

(3) Each category of patient surveyed would prefer that the other relative and friend visitor have their visiting time restricted to a thirty minute visit.

(4) Regardless of the patient category surveyed, there was a preference for restricting the period of time during the day that other relatives and friends would be allowed to visit.

(5) The admissions and outpatient categories of patients surveyed felt that there should be no restriction on when the immediate family members would be allowed to visit. In contrast,

interesting point

the inpatients surveyed felt that there should be a restriction on the visiting of the immediate family member. This tracks well with the hypothesis that a patient's preference for visitors would change as they move along the continuum.

(6) Of those patients surveyed that felt restricted visiting hours should be in effect, answering "yes" to question four in any section, the following applied:

Outpatients and admissions categories responding felt that evening hours were best for all, where inpatients responding, agreed with the evening hours for other relatives and friends, but wanted morning, afternoon, and evening hours for the immediate family. This would appear to be in some conflict with finding (5) above; however, I feel that any conflict is created by the wording of question three and four themselves. A logical overall finding for these two questions combined would be, a restriction on the visiting of other relatives and friends, preferably to the evening hours, and unlimited visiting for the immediate family visitor.

(7) Regardless of the patient category surveyed, all agreed that no visitor should be in the room when medical care was being received.

(8) All patients surveyed felt that they should have some time free from being visited by anyone.

(9) All patients surveyed felt that the children of the immediate family should be allowed to visit regardless of age. but would restrict children of all other visitors to some set age limit.

(10) Outpatients surveyed generally felt that there should be more unlimited visiting as pertains to the number of visitors than either the admissions or inpatient categories.

(11) Although it has already been stated how the patients surveyed felt to restricted or prescribed visiting hours for each category of visitor, it is interesting to note that the feelings were progressively stronger from the outpatient to the inpatient.

(12) Generally, the responses to questions formed a pattern with outpatients on one end, and inpatients on the other, with admissions falling somewhere between.

From the above findings, the hypothesis has been supported on both parts. If we concur with some authors, that too often we design policies at the expense of patients rather than for them, the proper action would be to form a policy around these findings. Given that this is accepted, the bulk of the remaining part of this paper will present sections which, when combined, form this policy based on the questionnaire results.

Visitor Badges

Since the preference indicated by the survey was for some restriction on visitors, there is a need to be able to identify and control flow within as well as access to the facility. Every author writing about a visitor control program relates the use of some type of badge for that purpose. This badge is seen as a necessary part of this facility's policy.

The survey finding of limiting the visitors to two at one time can be controlled by the use of this visitor badge. Each patient will have two badges at the information desk, which will be held in a special storage rack designed for that purpose. This storage rack (Appendix G) will be divided into sections. Each section will represent a ward except for the final section called "Special". The number of slots to hold badges in each section will correspond to the bed locations on that ward. The location for this rack at the information desk is shown at Appendix H. As the visitors arrive and indicate the name of the patient they wish to visit, those particular badges will be issued. As other visitors arrive to visit the same patient, a glance can tell that two are already at the bedside, and they must wait until the visitors return with

the badge. Additionally, a glance can tell exactly how many visitors are in the facility, and where they are located. The special section will contain badges to be issued to individuals who have "special" requirements. They are business representatives, VIP's, and visitors of patients with terminal or critical conditions who have been extended special privileges.

The badges that will be stored in this rack must be designed so that the badge controls their flow within the facility, or in effect limits their visiting only to the ward, and bed where their patient is located. To do this a color scheme has been selected that assigns each floor a color, with extra colors for the special visitor. These colors are as follows:

Floor 2	White
Floor 3	Green
Floor 4	Yellow
Floor 5	Pink
Floor 6	Blue (Light)
Floor 7	Silver
Floor 8	Orange
Floor 9	Brown
Special	Red - for visitors of terminal, critical, or other patients so authorized
	Purple - for VIP's, business representatives, etc.

The visitor will be issued the color badge that corresponds to the floor on which their patient is located. When a visitor is found at any other location not authorized their particular color badge, they will be escorted back to the appropriate area, or to the information desk. Example: A

visitor to the second floor will be issued a red badge authorizing them to visit that floor only. Added at this point is that the badges will also contain the bed number of the patient they are to visit, which further controls their flow within the ward area. Due to construction at present, this bed number procedure is impossible to implement. Appendix N provides a display by floor of the completed electrical mechanical upgrade construction, and the required bed locations with the recommended numbering.

Appendix F provides pictures of the type of badges that were considered for use in the above described procedures. These badges were obtained through contact with other facilities and activities, as evidenced by the activities name remaining on the badge. A few brief comments have been provided at each badge giving some of the characteristics of the badge, and positive or negative points. Requirements for the badge were that it: (1) be attractive, (2) have the ability to be colored, (3) attach to the visitor's clothing without tearing it, (4) be durable, (5) be large enough for easy visibility, but small enough for wearing, while presenting an obstacle to carrying it out of the facility, (6) and be suitable for storage in the rack designed. These badges were exposed to the Consumer Health Education Committee of Martin Army Hospital for their opinion of which badge would be best.

As a result, badges 5 a-c, Appendix F, were designed incorporating the qualities of the others that were preferred. Badge 5c was chosen as the badge design for the policy as best meeting the needs. It would be made of metal for durability, take the size and shape of the plastic ID card type badge, utilize the bulldog clip attachment device, and be easily placed in the storage rack slots.

A cost analysis of these different badges follows. It is based on ordering one thousand badges.

Badge Number 1 = Round metal open back safety pin

Cost:	\$130.00 per thousand	\$130.00
	3.50 per background color change x 9	31.50
		<hr/>
	Total:	\$161.50

Badge Number 2 = ID card type with bulldog clip

Cost:	17¢ per bulldog clip x 1,000 =	\$ 170.00
	6¢ per plastic pouch x 1,000 =	60.00
	Labor = One GS-3/1 completing one badge every three minutes or 20 badges per hour requiring 50 hours of labor at \$3.81 per hour	190.50
	Card Insert = 3 x 5 card x 1,000	<hr/> 8.50
	Total:	\$ 429.00

Badge Number 3 = Plastic pouch safety pin back

Cost:	17¢ per 1,000	\$ 170.00
	Card Insert = 3 x 5 card x 1,000	8.50
		<hr/>
	Total:	\$ 178.50

Badge Number 4 = Stick-on visitor badge

Cost:	\$18.00 per 1,000 on a roll with 10 rolls needed for color re- quirements	\$ 180.00
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Total:	\$ 180.00
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NOTE: This is a recurring cost.

Badge Number 5a = Round metal badge with bulldog clip

Cost:	17¢ per 1,000 for metal back round pin	\$ 170.00
	17¢ per 1,000 for bulldog clip	170.00
	\$3.50 per background color change x 9	31.50

Total:	\$ 371.50
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Badge Number 5b or c = Metal badge with bulldog clip

Cost:	\$196.00 per 1,000	\$ 196.00
	17¢ per 1,000 for bulldog clip	170.00
	\$3.50 per background color change x 9	31.50

Total:	\$ 397.50
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On cost alone the badge number one would be the choice. The other requirements, when placed in effect, negate the ability to use cost alone as the criteria.

Information Desk

To aid in the control of visitors, a channeling or forced direction of people was felt needed. For this action, a redesign of the information desk was necessary (Appendix H).

This redesign extends the desk across the main lobby, which forces visitors to cross in front of the receptionist as they try to enter into the hospital proper. This extension still allows for the required corridor width for areas used as exits during emergencies. With this redesign, the information desk receptionist can control access to the hospital by having all personnel routed through their area. Hospital staff, of course, will be allowed to enter and exit freely.

By extending this desk forward, a large area is opened for administrative space that was critically needed by the Patient Administration Division Activity. The receptionist will sit at the end of the desk that leads into the elevator area where two service windows are present. One window will serve the people as they arrive, and one will serve as a collection for badges returned, and to answer questions from staff or those already granted access to the hospital proper.

The cost of this construction shown also at Appendix H is estimated at \$3400. The engineer estimate at Appendix H indicates \$6700 which includes a renovation of the adjoining admissions and disposition area. Since both areas require approximately the same work and are of equal size the above \$3400 figure is appropriate. The admissions area is included only because the designing was done for both areas, and submitted for estimate at the same time. The engineers could not separate the cost individually. This redesign of the Admissions and

Dispositions Area does not affect the visitor control policy in any way, and is shown only by virtue of it being part of a package. The completion of this construction is the key ingredient in the effectiveness of the visitor control policy, for without the requirement for visitors to be channeled, and therefore their flow into the facility controlled, the remaining part of the policy could not be implemented.

Personnel

At the point of entering into the hospital there must be some method for the visitor to obtain, and be given, information about Martin Army Hospital and its visiting policy. Someone must be able to assist the visitor who has a unique problem, and to control the length of visiting so that all get a chance to visit. These individuals we will call information desk receptionist, and as such they will staff the information desk.

To operate the information desk from 0700 hours until 2300 hours, seven days a week, there exists a requirement for six personnel. After 2300 hours, the desk will be operated only by Admissions and Dispositions personnel and the AOD or SDNCO. Currently there is a staffing of three information desk personnel, and in effect, this new requirement will double the staffing level. It will take as a minimum two personnel per shift in order to accomplish the necessary duties.

Since there will be six personnel, and due to the variety of tasks to be accomplished, as well as the myriad of activities that must be coordinated with, a lead information desk receptionist is felt to be necessary. A job description for this lead receptionist and the other five receptionists are attached at Appendix I and J respectively.

As the construction of the information desk was critical to a successful program, so is the staffing of the desk with sufficient personnel.

Staff Entrances

Hospital staff must have free and easy access to the facility, and by virtue of their staff status, may not be required to use the same entrances as visitors. Basically entrance requirements are determined by parking facilities, and their location around the facility. At Martin Army Hospital as indicated by figure 44, the parking lots are located in a half-circle configuration around the three main entrances. The most direct routes to the facility are toward these three entrances. There are no other parking areas with the exception of the logistics parking which has no requirement for after hours use, nor is there any reason a physician, nurse, or other personnel should need access through that entrance.

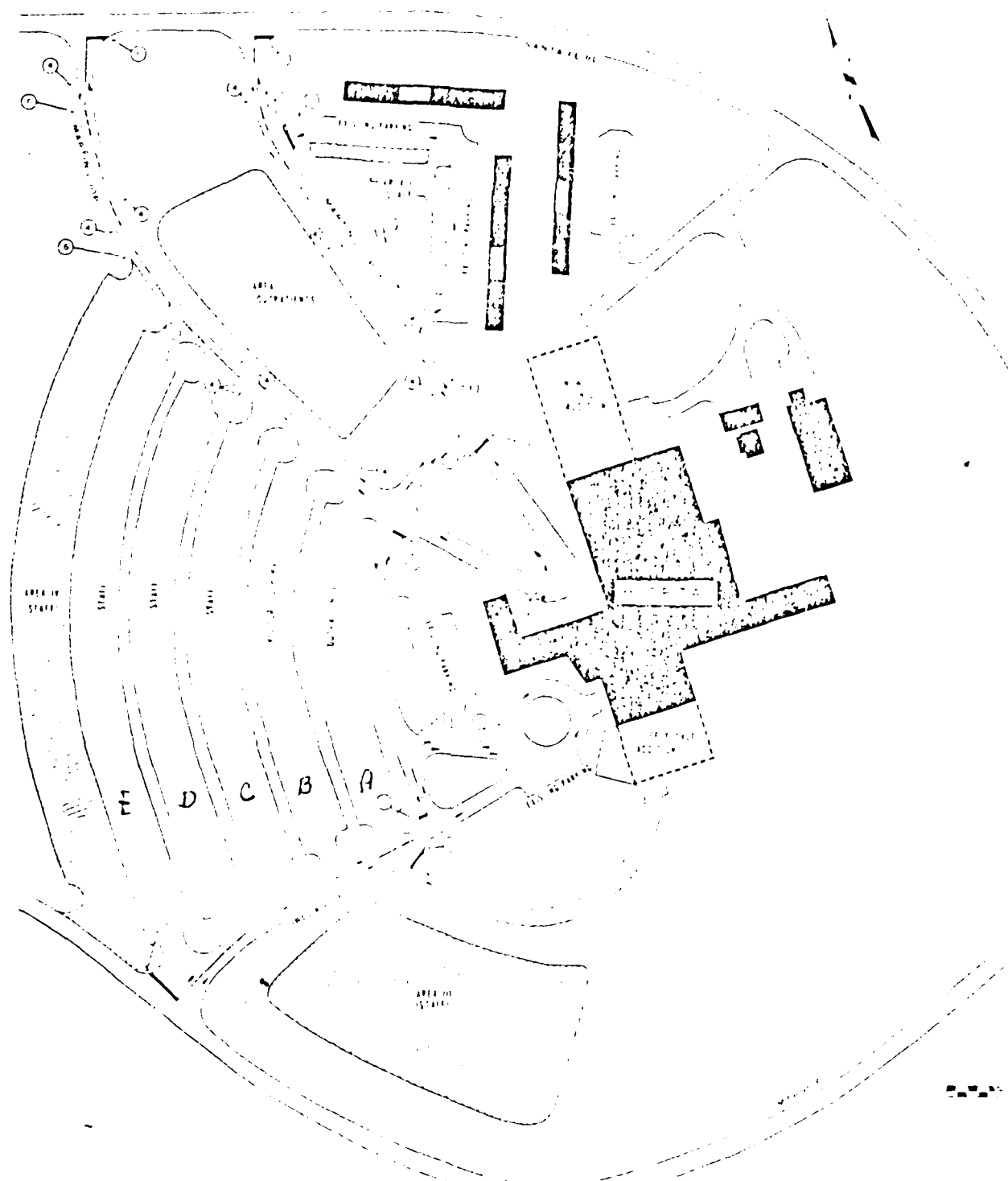


FIGURE 44

Therefore, only the main entrance and the emergency entrance will remain open after 1630 hours. All other entrances will be closed. Staff personnel should use any of the three primary entrances during duty hours, and either of the two remaining open, after duty hours. Figure 43 depicts the twenty-eight doors that provide some access to the facility.

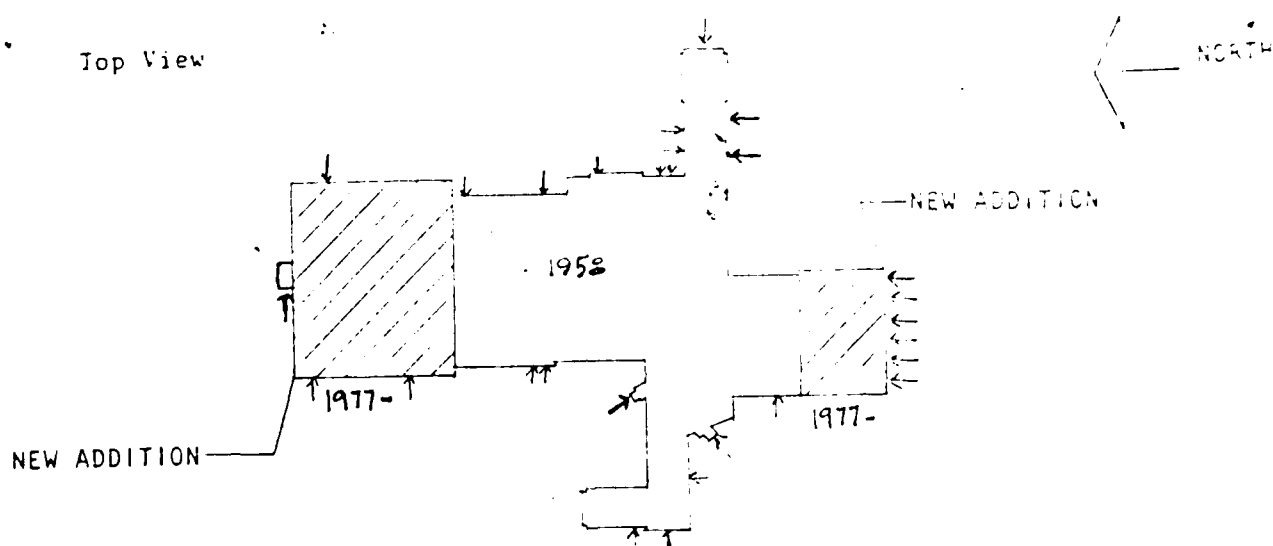


FIGURE 43

Visitor Entrances

Visitors to patients on the wards will be instructed to use the main entrance at all times. Since visiting hours are open during the hours that clinics are still in operation, a problem is anticipated where visitors enter through the emergency or clinic entrance. Signs must be posted at strategic locations to assist in eliminating this problem. Additionally, a strong visitor education program is mandated.

All entrances except the main entrance and the emergency entrance will be closed after normal duty or 1630 hours. The emergency entrance will be used for patients to that area and staff only. All visitors and patients to night clinics must enter through the main entrance. All exits may be used in an emergency. Appendix L and M provide the wording for signs to be used to control the flow of visitors, and the sites for their location.

Military Police

It was given in the limitations that the hiring of a security force was impossible due to manpower constraints. Some form of security is necessary to ensure compliance with any established policy. The security for outside of the facility is held to be a post support mission, and therefore the

military police of Fort Benning assume this responsibility. The security for inside the facility has been determined to be an internal problem, and up to the hospital to enforce. Here enters the problem as the visitor is internal, and therefore the facility's problem. Primarily, the security force will consist of hospital employees, and the AOD/SDNCO individuals. Additionally, even though internal security is passed to the facility, the military police at Fort Benning have agreed to place one military policeman in the facility from 1600-0800 hours daily. The internal support agreement between Martin Army Hospital and the military police is attached at Appendix K, with paragraphs one and ten of particular interest. Although they are not specifically concerned with visitor control, the MP's presence, and actions required should have a positive impact on the effectiveness of the policy. With this particular arrangement immediate military police reaction is available during the time visiting should be at its peak.

Bed Locations

Not only for patient and staff protection, but also for visitor protection, the location of all visitors as precisely as possible must be known. As part of the visitor control program to support this concept is the placing of the bed

number to which the patient is assigned on the visitor badge. This requires that the Nursing Service, and the Admissions personnel communicate the bed assignments to the information desk personnel. The fixed or permanent locations of beds will become mandated by the electrical and mechanical upgrade assuring the viability of this aspect of the visitor policy. The construction will not be completed until late 1979, during which wards are moved around as needed. Therefore, the bed number ^{was} part of the policy will not be placed in effect until that time. Appendix N provides a display by floor of the completed electrical mechanical upgrade construction, and the proposed bed numbering sequences.

Visitor Regulation

A draft of the proposed visitor regulation, and therefore the visiting policy for Martin Army Hospital incorporating the results of the survey and other policies is attached at Appendix O.

Visitor Brochure

Whatever policy is decided upon by Martin Army Hospital must be communicated to those who are affected by it - the visitor and the potential patient primarily, but also the staff. In this regard, a visitor's brochure has been prepared and

attached at Appendix P relating this policy, and some thoughts behind its development to our population. This brochure will become an integral part of patient education, and community education. The attempt has been to show that the visitor is important to the health care provided the patient, and therefore a part of the health care team of Martin Army Hospital. It places the responsibility for visiting, and some of the responsibility for the proper recovery of the patient on the visitor. It has been done so intentionally, feeling that the more involved the visitor becomes, the more apt they are to follow policy, and police the system themselves. The front cover depicts this visitor as part of the team. The actual size of the folder will be 8 x 11, with printing on each side. Each of the six pages at Appendix P will be reduced to one-third of its size allowing three pages per side of 8 x 11 paper. The 8 x 11 paper will then be folded in thirds, and distributed as a single copy booklet.

Conclusion

The following conclusions were reached:

- (1) That visitors can have an impact on patient care, specifically as it pertains to length of stay,
- (2) That good visiting, and the visitor policy designed for Martin Army Hospital based on the survey, mandates visitor

control as part of the program,

(3) That because of the proximity of the parking areas to the primary entrances, no additional staff entrances are needed, therefore no special locking devices for any auxillary entrances need be considered.

(4) That the survey results supported there is a difference in the way patients desire to be visited by the immediate family member, the other relative, and the good friend.

(5) That the survey results supported there is a difference in the patient's visiting preferences from the time they are outpatient until they have been hospitalized at least three days.

(6) That the visitor control program as depicted in the visitor regulation and visitor brochure incorporates the feeling of patients, as well as the current literature on the subject of visiting and therefore should be the visitor policy for this facility.

RECOMMENDATIONS

The following recommendations are made:

- (1) That the visitor regulation as shown be approved and published.
- (2) That the visitor brochure as shown be approved and published.
- (3) That approval be granted to hire the additional staff for the information desk.
- (4) That funds be made available to renovate the information desk.
- (5) That the Public Affairs Office make the widest dissemination of the new visitor policy once approved.
- (6) That the standardization of bed locations be implemented at the earliest according to Appendix N.
- (7) That funds be made available to procure the visitor badges as proposed by Appendix F.
- (8) That the storage rack at Appendix G be constructed.
- (9) That the signs at Appendix L and M be approved for procurement.

FOOTNOTES

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- ¹⁸_____, "Security System is Used by Many Southern Hospitals, Pinkertons," Southern Hospital, 36: December 1968, page 22.
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- ²⁰Peter W. Speck, "The Hospital Visitor," Nursing Times, 69: July 5, 1973, page 878.
- ²¹James P. Hackness, Robert R. Cadmus, and Robert R. Hafner, "Patient Visitors in North Carolina Hospitals," Hospital Administration (Chicago), 13: Spring 1968, page 39.
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APPENDIX A

Questionnaire

1 March 1975

Dear Patient:

We are studying the current visiting policies at Martin Army Hospital to determine if changes are needed. We want to know what you think before we make any changes. Here is your chance to get your ideas heard.

This questionnaire which you are being asked to complete is divided into three sections - one section for each of three categories of visitors: IMMEDIATE FAMILY, OTHER RELATIVES, and FRIENDS. Each section asks the same questions. The reason for the separate sections is that when you answer the questions for one section, we want you to think about only one category of visitor. For example, Section I is the Immediate Family Section and responses to those questions should be made only thinking about your immediate family members being the visitors. Therefore, responses to Sections II and III should be made with only their particular visitor in mind.

We appreciate your taking the time to help. Thank you!!

PATIENT QUESTIONNAIRE

SECTION I: IMMEDIATE FAMILY MEMBERS

(Sister, Brother, Wife, Husband, Children, Mother, Father, etc.)

(When you answer these questions, only consider how you would feel toward your immediate family and not other relatives or good friends.)

1. How many immediate family members should you be allowed to have at your bedside at one time?

- ☐ One.
- ☐ Two.
- ☐ Other: _____
- ☐ No limit.

2. How long should your immediate family members be allowed to visit?

- ☐ 10 Minutes.
- ☐ 15 Minutes.
- ☐ 20 Minutes.
- ☐ 30 Minutes.
- ☐ Other: _____
- ☐ No limit.

3. Should there be prescribed or set visiting hours for your immediate family members?

- ☐ Yes.
- ☐ No. (Means 24 hours a day visiting is permitted).

(If you answered "No," go to Question #6).

4. At what time(s) during the day should your immediate family members be allowed to visit?

- ☐ Morning Visiting Hours.
- ☐ Afternoon Visiting Hours.
- ☐ Evening Visiting Hours.
- ☐ All of the above.

5. When do you feel that the visiting hours for your immediate family members should start and end? (Complete only for those you checked in Question #4).

Morning

Start: _____

End: _____

Afternoon

Start: _____

End: _____

Evening

Start: _____

End: _____

6. Should your immediate family members be present when you are receiving care, being visited, or otherwise assisted by medical personnel?

☐ Yes.

☐ No.

7. Should you have some time during the day free from being visited by immediate family members?

☐ Yes.

☐ No.

8. Do you feel that children in your immediate family should be allowed to visit regardless of age?

☐ Yes.

☐ No. Please give age that you would allow for visiting privileges.
AGE: _____

• SECTION II. OTHER RELATIVES

(When you answer these questions, only consider how you would feel toward your other relatives as the visitor and not your immediate family or good friends.)

1. How many of your "other relatives" should you be allowed to have at your bedside at one time?

☐ One.

☐ Two.

☐ Other: _____

☐ No limit.

2. How long should your "other relatives" be allowed to visit?

- ☐ 10 Minutes.
☐ 15 Minutes.
☐ 20 Minutes.
☐ 30 Minutes.
☐ Other: _____
☐ No limit.

3. Should there be prescribed or set visiting hours for your "other relatives?"

- ☐ Yes.
☐ No. (Means 24 hours a day visiting is permitted).

(If you answered "No," go to Question #6):

4. At what time(s) during the day should your "other relatives" be allowed to visit?

- ☐ Morning Visiting Hours.
☐ Afternoon Visiting Hours.
☐ Evening Visiting Hours.
☐ All of the above.

5. When do you feel that the visiting hours for your "other relatives" should start and end? (Complete only for those you checked in Question #4).

Morning
Start: _____
End: _____

Afternoon
Start: _____
End: _____

Evening
Start: _____
End: _____

6. Should your "other relatives," as visitors, be present when you are receiving care, being visited or otherwise assisted by medical personnel?

- ☐ Yes.
☐ No.

7. Should you have some time during the day free from being visited by your "other relatives?"

☐ Yes.

☐ No.

8. Do you feel that children of your "other relatives" should be allowed to visit regardless of age?

☐ Yes.

☐ No. Please give age that you would allow for visiting privileges.

AGE: _____

SECTION III: FRIENDS

(When you answer these questions, only consider how you would feel toward your friends and not immediate family and other relatives).

1. How many of your "friends" should you be allowed to have at your bedside at one time?

☐ One.

☐ Two.

☐ Other: _____

☐ No limit.

2. How long should your "friends" be allowed to visit?

☐ 10 Minutes.

☐ 15 Minutes.

☐ 20 Minutes.

☐ 30 Minutes.

☐ Other:

☐ No limit.

3. Should there be prescribed or set visiting hours for your "friends?"

☐ Yes.

☐ No. (Means 24 hours a day visiting is permitted.)

(If you answered "No," go to Question #6).

4. At what time(s) during the day should your "friends" be allowed to visit?

- ☐ Morning Visiting Hours.
☐ Afternoon Visiting Hours.
☐ Evening Visiting Hours.
☐ All of the above.

5. When do you feel that the visiting hours for your "friends" should start and end?

Morning

Start: _____

End: _____

Afternoon

Start: _____

End: _____

Evening

Start: _____

End: _____

6. Should your "friends" be present when you are receiving care, being visited, or otherwise assisted by medical personnel?

- ☐ Yes.
☐ No.

7. Should you have some time during the day free from being visited by your "friends"?

- ☐ Yes.
☐ No.

8. Do you feel that children of your "friends" should be allowed to visit regardless of age?

- ☐ Yes.
☐ No. Please give age that you would allow for visiting privileges.
AGE: _____

SECTION IV: GENERAL

1. Please give your age: _____

2. (Please answer only if you are already an in-patient or are being admitted.)
Your condition for which you are being admitted is --

- ☐ Medical. ☐ Surgical. ☐ Psychiatric.

"T H A N K Y O U"

APPENDIX B

MATRIX BY NUMBER OF RESPONSES TO EACH QUESTION CHOICE

QUESTION NR.	ADMISSIONS	OUTPATIENTS	INPATIENTS	ADMISSIONS	OUTPATIENTS	INPATIENTS	ADMISSIONS	OUTPATIENTS	INPATIENTS	ADMISSIONS	OUTPATIENTS	INPATIENTS	SECTION NR.
1 =	6	6	0	56	42	27	22	17	21	53	46	24	= I
1 =	16	13	3	62	55	37	8	13	10	35	25	17	= II
1 =	17	11	6	57	57	29	19	10	14	31	26	18	= III
2 =	0	1	0	2	3	1	6	5	4	30	21	15	27 25 20 74 55 33 = I
2 =	2	4	1	12	17	5	15	7	6	45	32	19	16 17 19 33 28 19 = II
2 =	3	7	2	19	21	6	18	4	4	38	31	24	7 10 9 34 29 24 = III
3 =	58	40	40	74	72	32	= I						
3 =	86	77	57	37	27	12	= II						
3 =	86	74	57	29	28	14	= III						
4 =	6	3	0	17	17	18	28	19	17	25	13	25	= I
4 =	8	5	1	33	37	29	48	45	29	12	15	16	= II
4 =	5	6	3	38	37	22	55	45	32	7	12	17	= III
6 =	44	33	22	84	74	45	= I						
6 =	14	12	11	106	94	58	= II						
6 =	8	7	10	111	96	61	= III						
7 =	92	72	48	39	32	18	= I						
7 =	100	88	55	19	15	13	= II						
7 =	102	91	56	16	12	14	= III						
8 =	72	61	36	57	45	30	= I						
8 =	37	30	24	82	72	41	= II						
8 =	35	22	19	84	82	51	= III						

LEGEND:

Question Number Column - Self Explanatory
Admissions Column - Responses by patients completing questionnaire at time of admission
Outpatient Column - Responses by outpatients completing questionnaire
Inpatient Column - Responses by inpatients completing questionnaire

SECTION COLUMN

I - Immediate family section of questionnaire
II - Other relatives section of questionnaire
III - Friends section of questionnaire

TABLE I

APPENDIX C

MATRIX BY NUMBER OF RESPONSES TO EACH QUESTION CHOICE
CONVERTED TO PERCENTAGES

QUESTION NR.	ADMISSIONS	OUTPATIENTS	INPATIENTS	ADMISSIONS	OUTPATIENTS	INPATIENTS	ADMISSIONS	OUTPATIENTS	INPATIENTS	ADMISSIONS	OUTPATIENTS	INPATIENTS	SECTION NR.
1 =	4	5	0	41	38	38	16	15	29	39	42	33	= I
1 =	13	12	5	50	52	55	7	12	15	30	24	25	= II
1 =	14	11	9	46	55	43	15	10	21	25	24	27	= III
2 =	0	1	0	2	3	1	4	5	5	22	18	22	19 23 27 53 50 45 = I
2 =	2	4	1	10	16	7	12	7	8	36	30	28	13 16 28 27 27 23 = II
2 =	3	7	3	16	21	9	15	4	5	31	31	35	6 10 13 29 28 35 = III
3 =	44	36	56	56	64	44	= I						
3 =	70	74	83	30	26	17	= II						
3 =	75	73	80	25	27	20	= III						
4 =	8	5	0	22	30	30	37	33	28	33	32	42	= I
4 =	8	5	1	33	36	39	47	44	39	12	15	21	= II
4 =	5	6	4	36	37	30	52	45	43	7	12	23	= III
5 =	34	31	33	66	69	67	= I						
5 =	12	12	19	88	88	81	= II						
6 =	7	7	7	93	93	93	= III						
7 =	70	70	73	30	30	27	= I						
7 =	84	85	81	16	15	19	= II						
7 =	86	88	80	14	12	20	= III						
3 =	56	57	55	44	43	45	= I						
8 =	31	29	37	69	71	63	= II						
8 =	30	21	27	70	79	73	= III						

LEGEND:

Question Number Column - Self Explanatory
Admissions Column - Responses by patients completing questionnaire at time of admission
Outpatient Column - Responses by outpatients completing questionnaire
Inpatient Column - Responses by inpatients completing questionnaire

SECTION COLUMN

I - Immediate family section of questionnaire
II - Other relatives section of questionnaire
III - Friends section of questionnaire

TABLE II
57

APPENDIX D

Graphs Depicting Horizontal Analysis

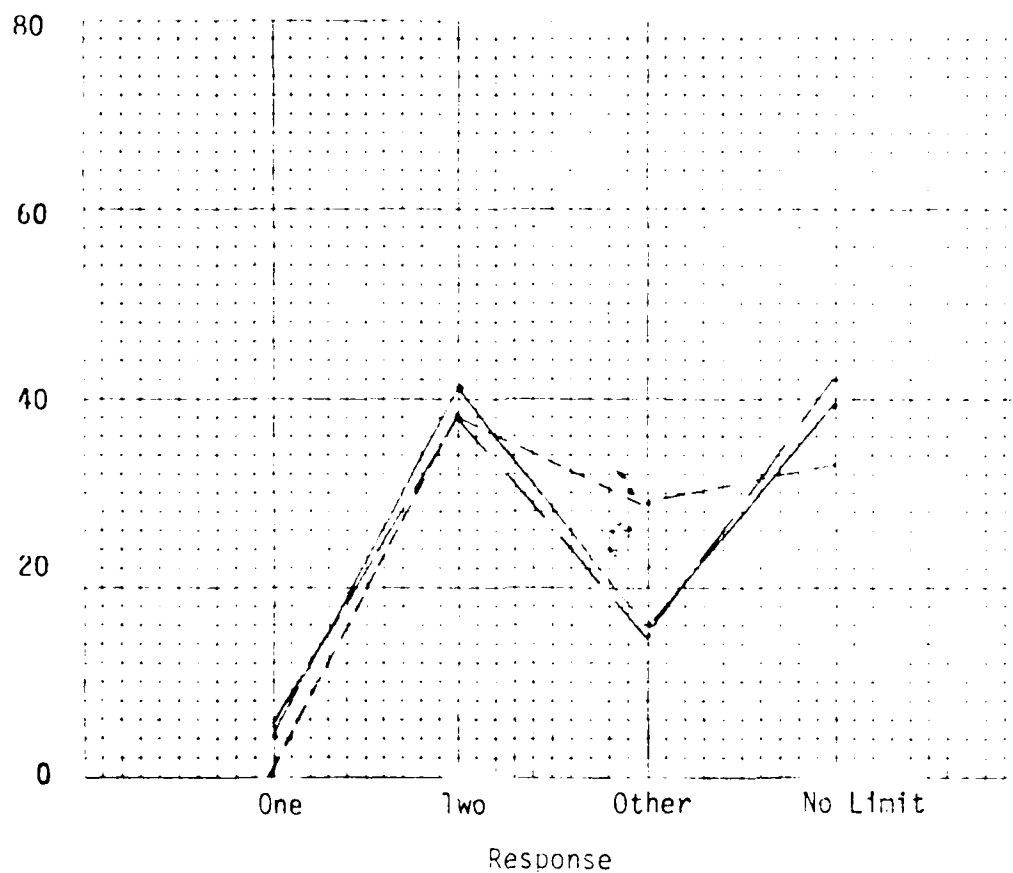
These graphs provide a horizontal analysis of the matrix.
The following legend applies.

———— = Admissions Patients Responding to Survey

—— ——— = Outpatients Responding to Survey

----- = Inpatients Responding to Survey

Percentage

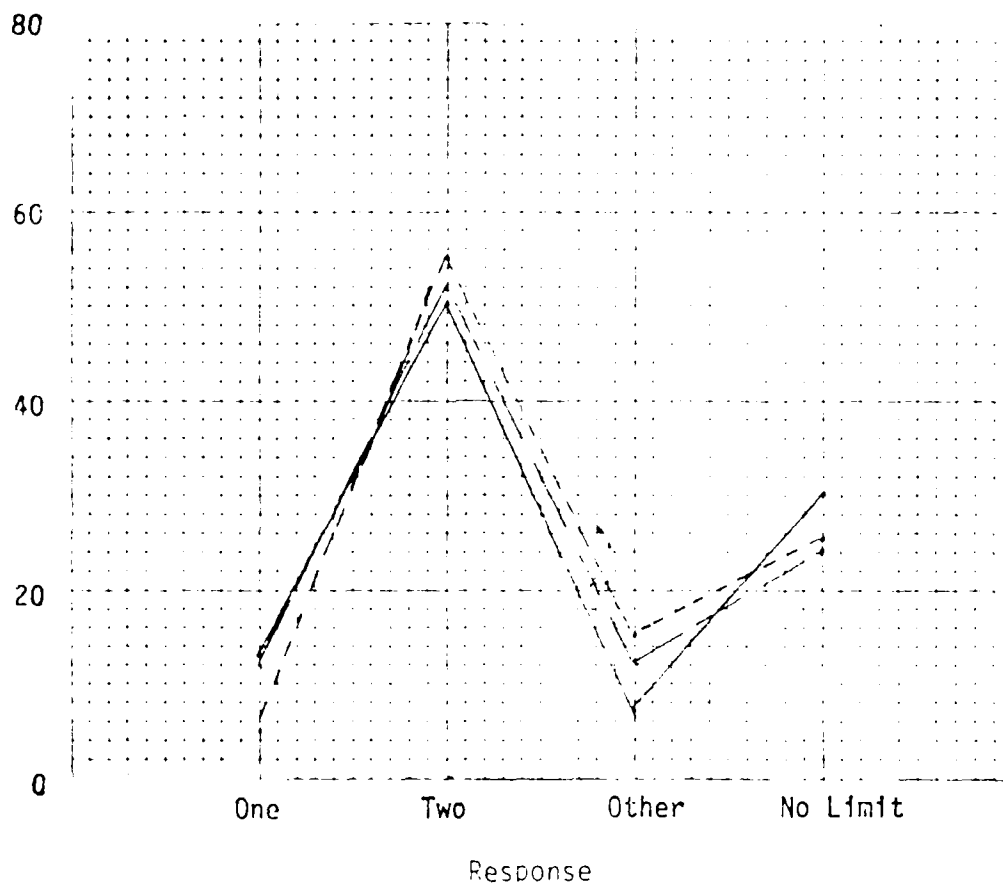


How each category of patients surveyed answered question #1, Section I.

FIGURE 1

Figure 1 shows a very consistent response selection by all categories of patients toward how many immediate family members should visit at one time. Most thought that either two or no limit were the preferred choices. Inpatients were slightly more vocal toward the third choice of other which usually ran from three - six.

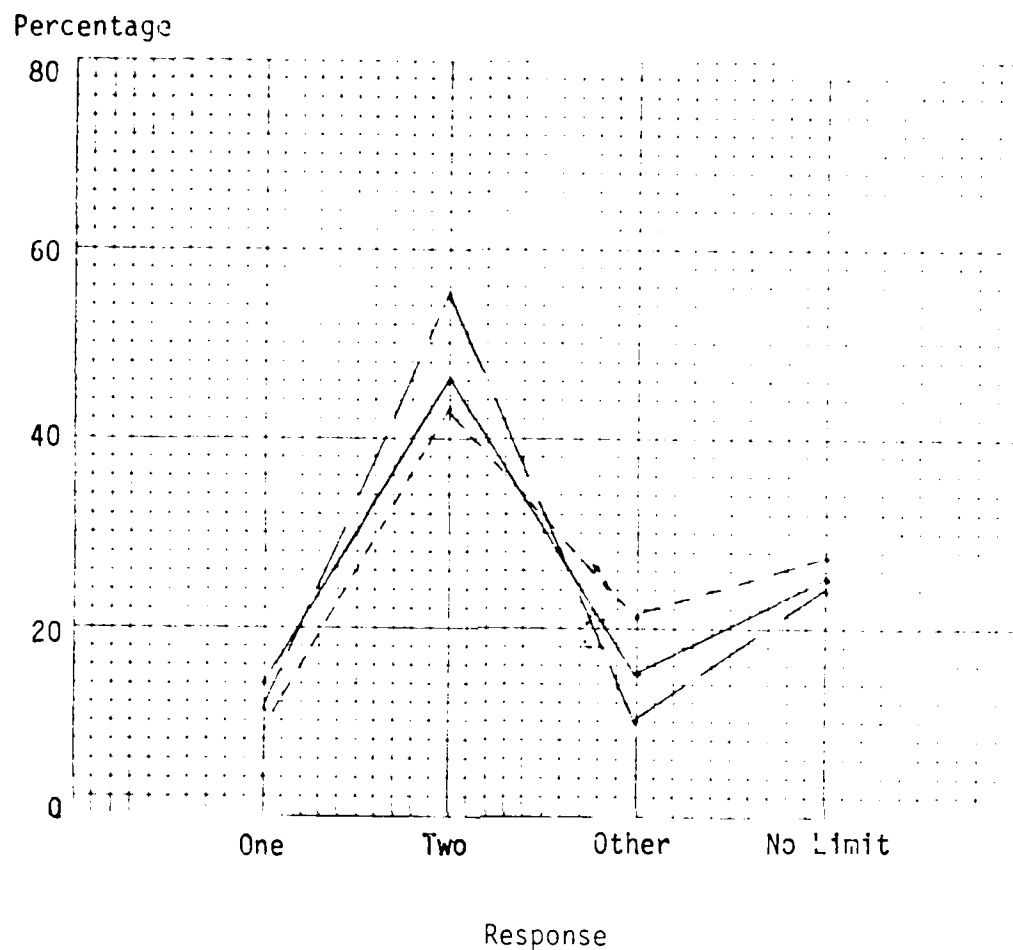
Percentage



How each category of patients surveyed answered question #1, Section II.

FIGURE 2

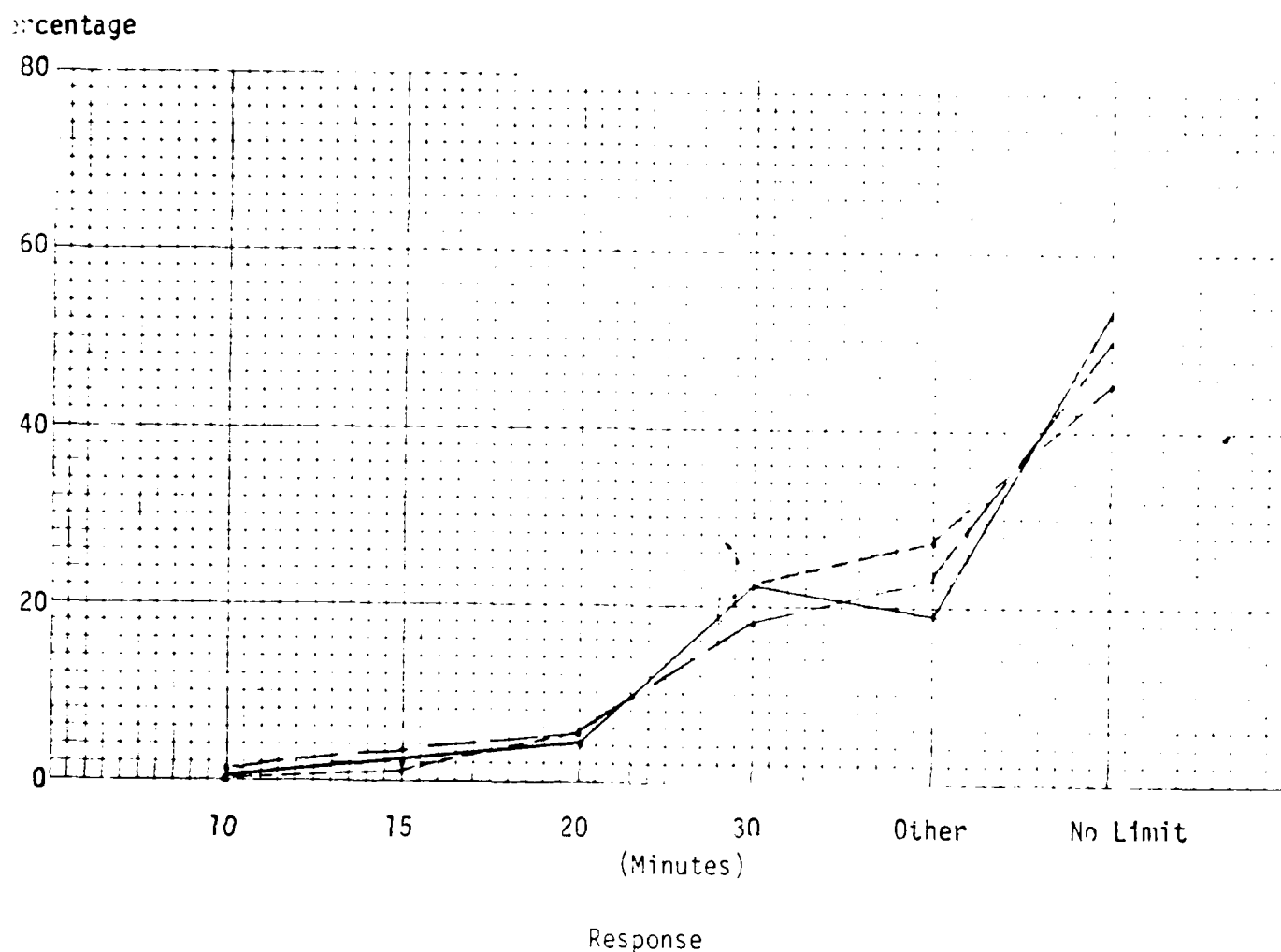
Figure 2 shows a consistent response selection by all categories of patients toward how many other relatives should visit at one time. The most preferred response was two. We do not find the same emphasis on no limit as was found applied to the immediate family member.



How each category of patients surveyed answered question #1, Section III.

FIGURE 3

Figure 3 shows a consistent response selection by all categories of patients toward how many friends should visit at one time. As in figures 1 and 2 the most preferred choice was two. In this particular graph we find an even lower response rate for the no limit category as applied to visiting friends.

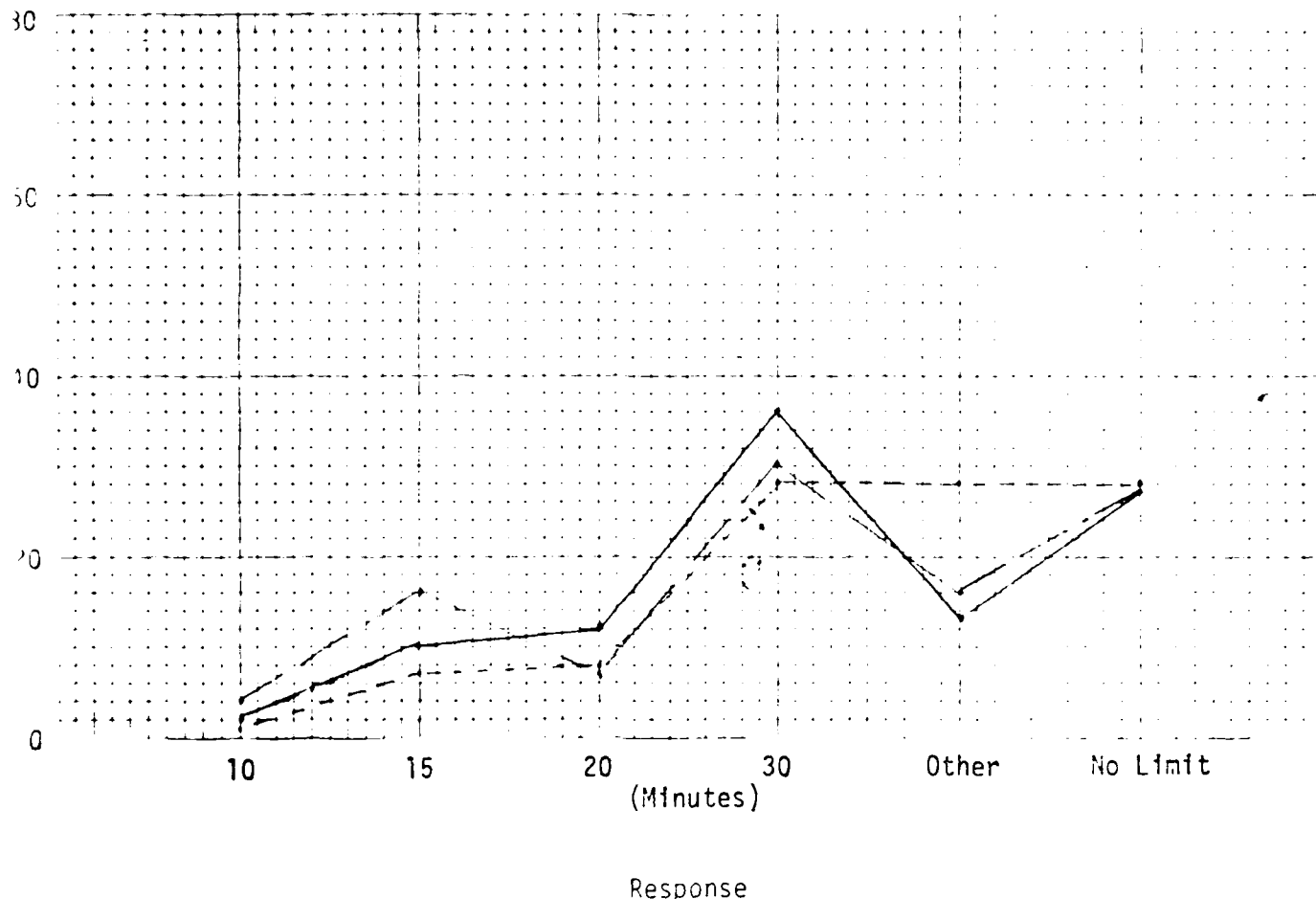


How each category of patients surveyed answered question #2, Section I.

FIGURE 4

Figure 4 shows a consistent response selection by all categories of patients toward how long immediate family members should visit. The most preferred choice was no limit with minimal consideration for any visiting of less than 30 minutes for immediate family.

Percentage

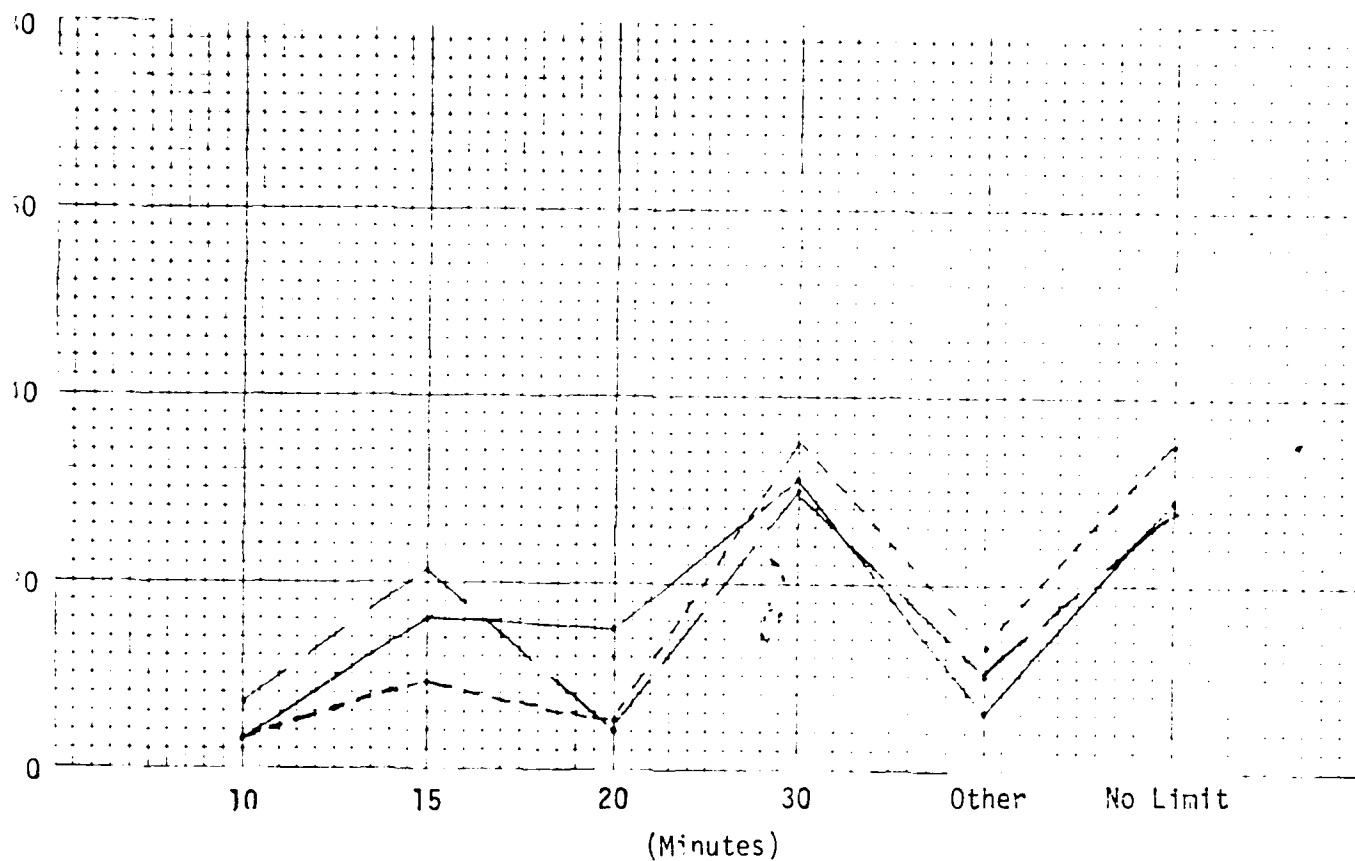


How each category of patients surveyed answered question #2, Section II.

FIGURE 5

Figure 5 depicts a consistent response selection by the admissions and outpatient categories, with the inpatient category consistent up through choice four, regarding how long other relatives should be allowed to visit. The most preferred choice was 30 minutes, or the fourth selection for all categories of patients, with inpatients showing no preference between the choices 30 minutes, other, and no limit.

Percentage

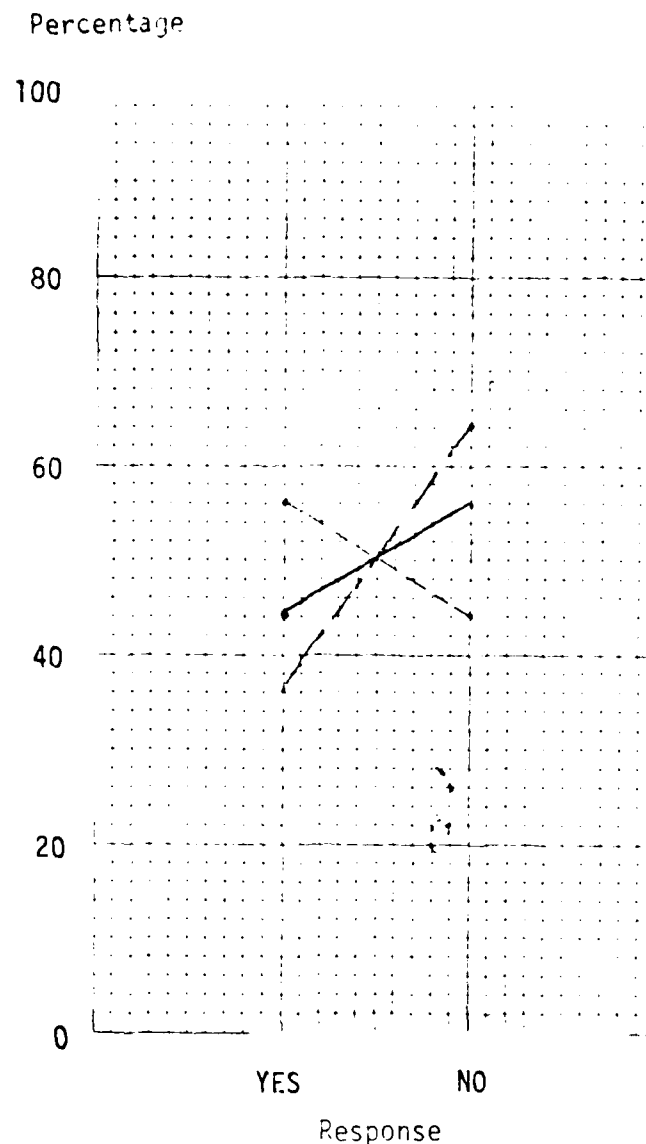


Response

How each category of patients surveyed answered question #2, Section III.

FIGURE 6

Figure 6 shows a consistent response selection by all categories of patients toward how long friends should be allowed to visit. The most preferred choice overall was the fourth choice, or 30 minutes with choice six or no limit, a very close second. It was not expected that friends would enjoy a high selection of no limit visiting time, than other relatives.

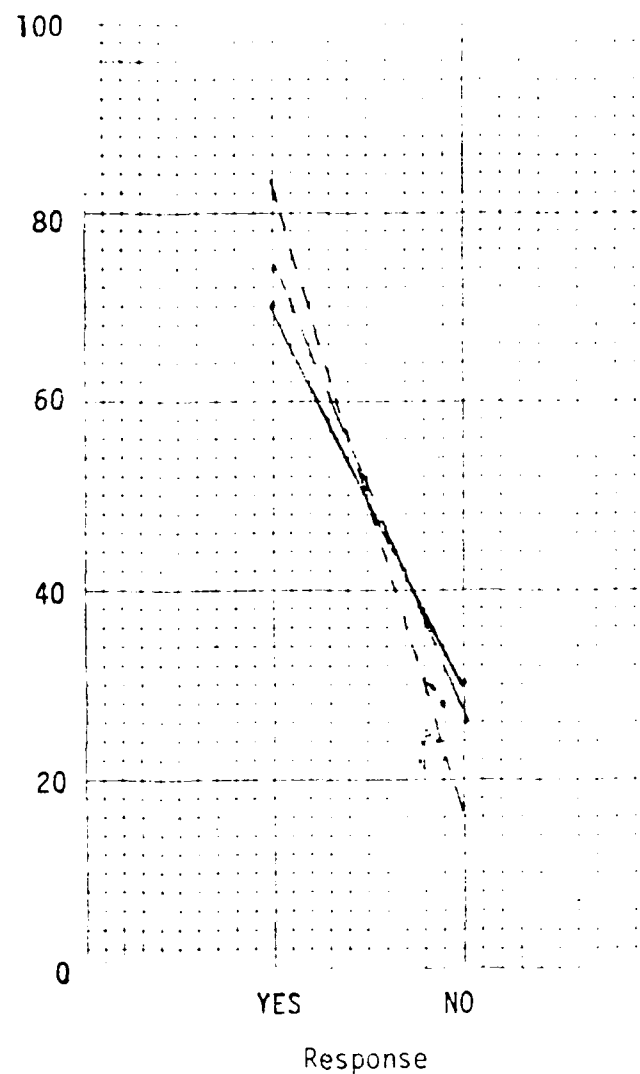


How each category of patients surveyed answered question #3, Section I.

FIGURE 7

Figure 7 depicts the response selection by all categories of patients to whether there should be prescribed or set visiting hours for the immediate family. Admissions and outpatient category patients felt much stronger than inpatients, that there should not be. Inpatients, on the other hand felt there should be set hours, more than they felt that there should not be. This could be a function of the degree of illness, but at this point it is only an assumption.

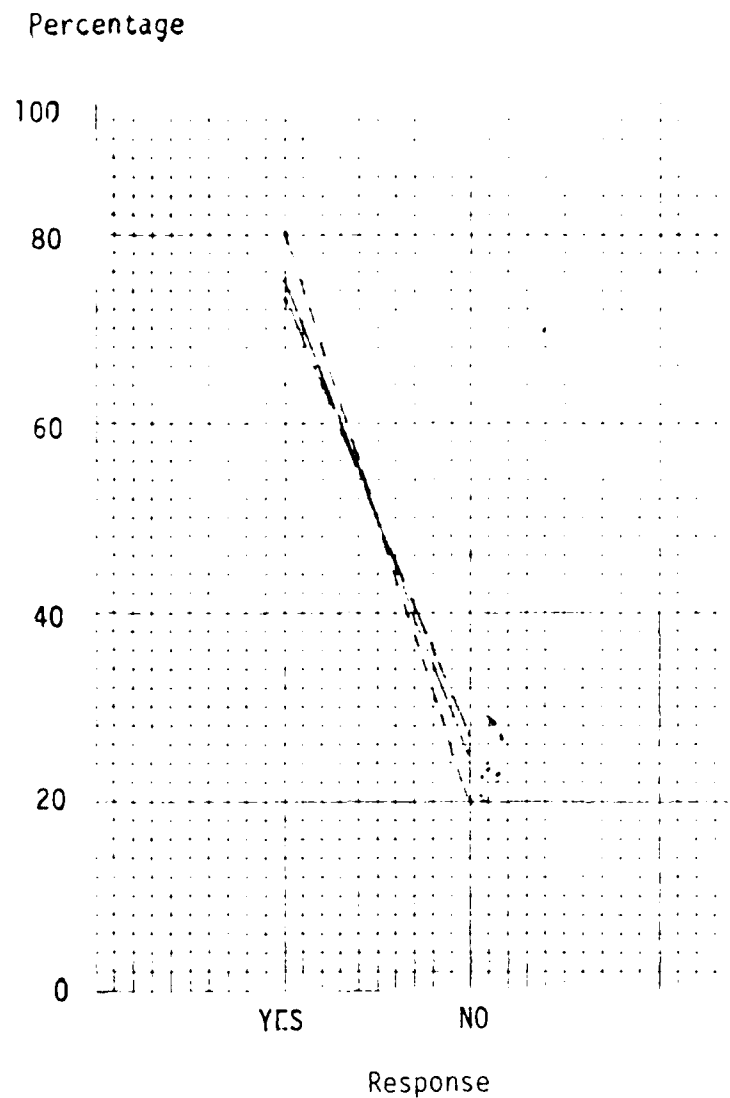
Percentage



How each category of patients surveyed answered question #3, Section II.

FIGURE 8

Figure 8 depicts a consistent response selection by all categories of patients to whether there should be set visiting hours for other relatives. By far the most preferred choice was "yes".

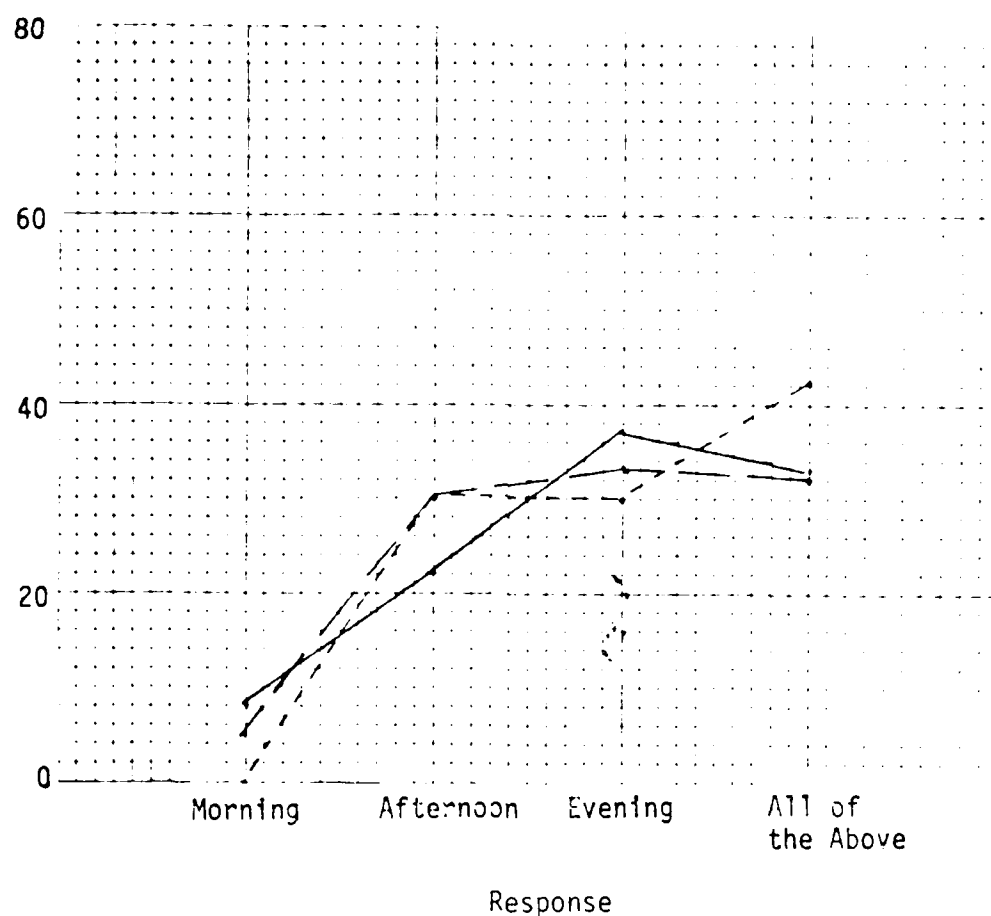


How each category of patients surveyed answered question #3, Section III.

FIGURE 9

Figure 9 depicts a consistent response selection by all categories of patients to whether friends should have set visiting hours. As in figure 8 the most preferred answer by far was "yes".

Percentage

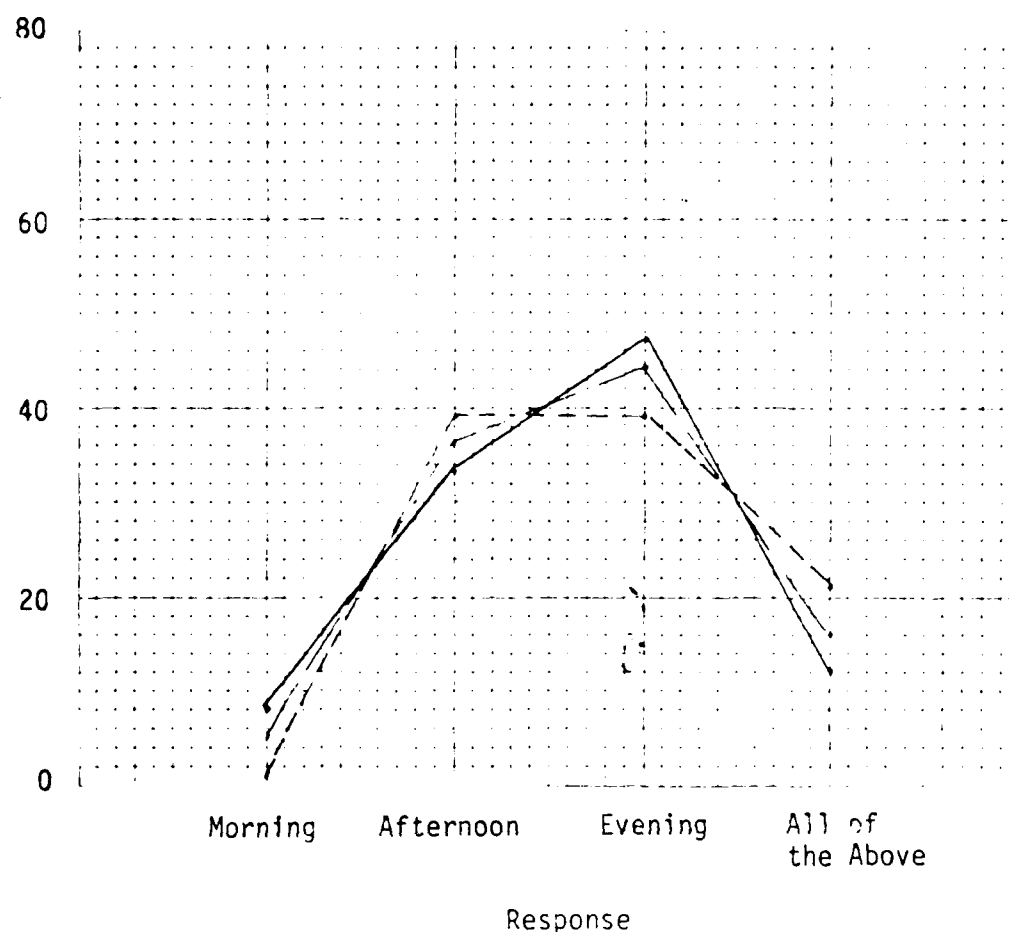


How each category of patients surveyed answered question #4, Section I.

FIGURE 10

Figure 10 shows a consistent response selection by all categories of patients regarding what time of the day immediate family members should be allowed to visit. There was little difference between admission and outpatient categories, with both approximately equally split between choices two, three, and four. Inpatients did exhibit a marked propensity for choice four, or morning, afternoon, and evening hours, which virtually means all day.

Percentage

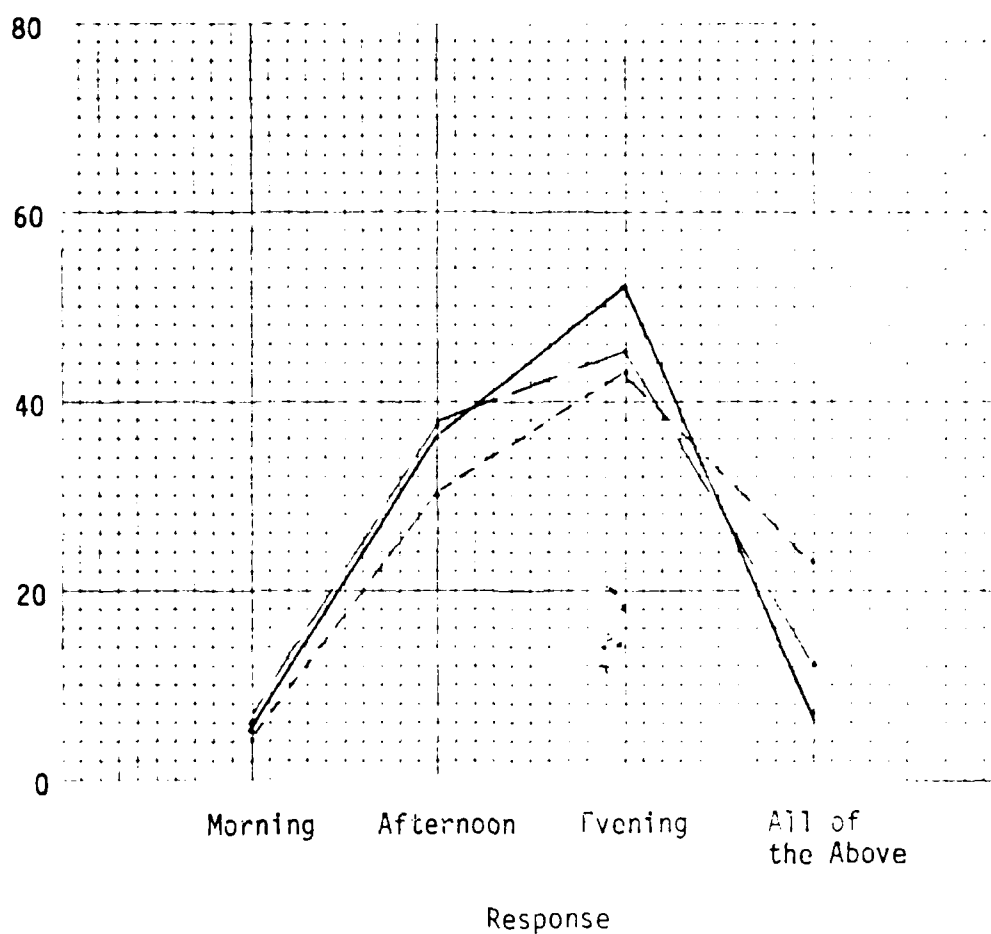


How each category of patients surveyed answered question #4, Section II.

FIGURE 11

Figure 11 shows a consistent response selection by all categories of patients towards the time of day for other relatives to visit. The most preferred choice was three, or evening hours. Very few, in contrast to figure 10, felt other relatives should visit all day.

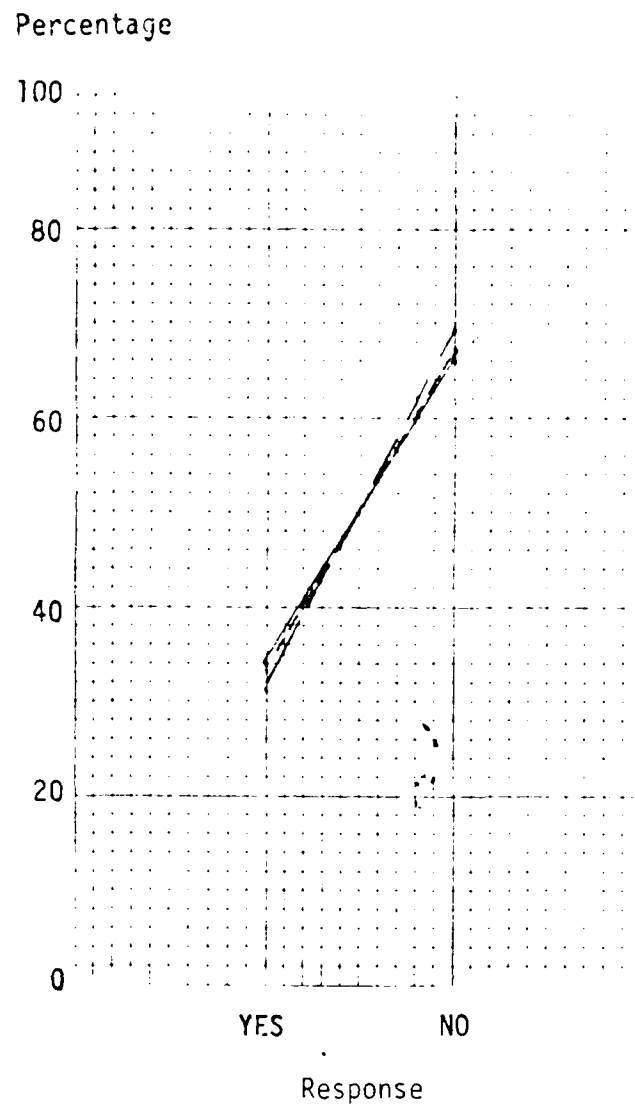
Percentage



How each category of patients surveyed answered question #4, Section III.

FIGURE 12

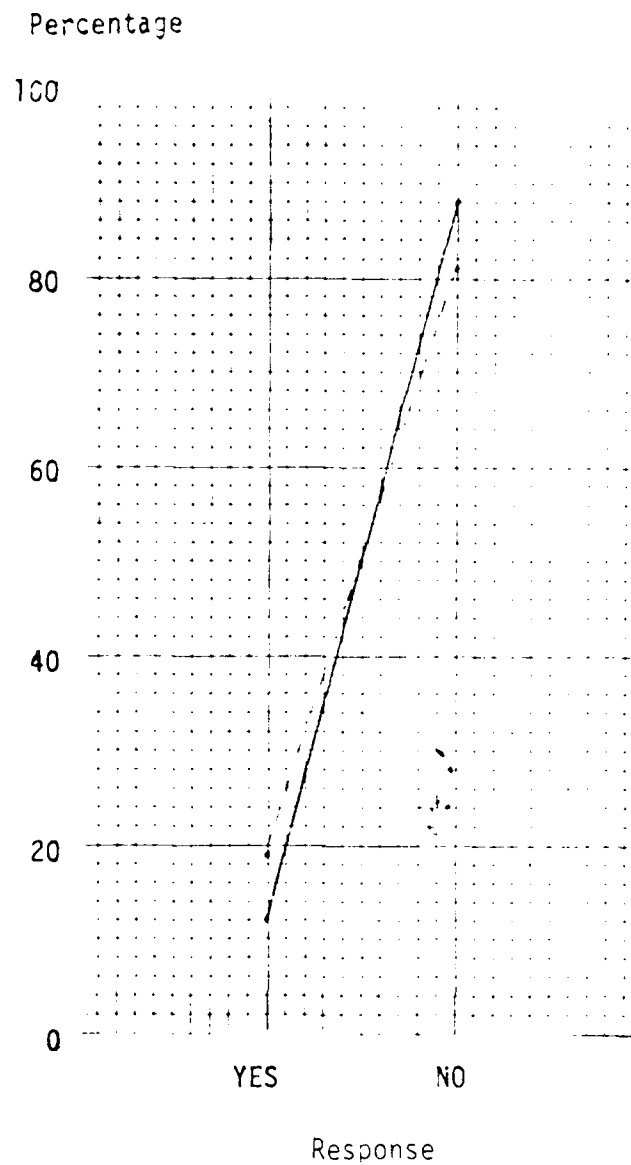
Figure 12 depicts an almost identical response selection as figure 11. By far, evening hours visitation was preferred for friends, with afternoon hours second. Very few felt that friends should visit all day.



How each category of patients surveyed answered question #6, Section I.

FIGURE 13

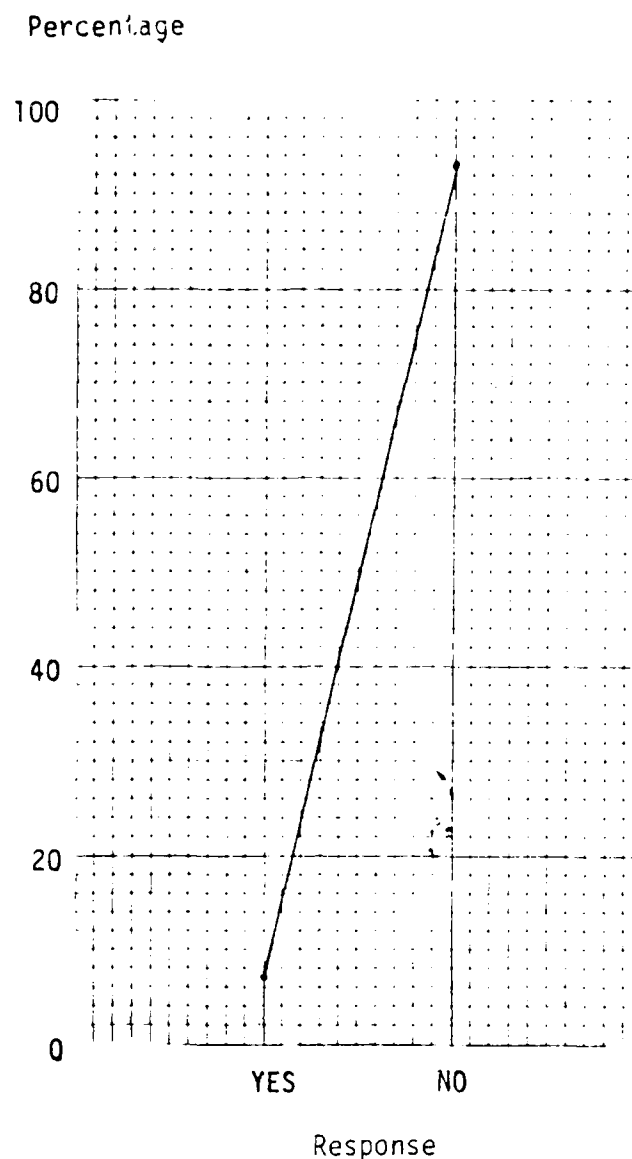
Figure 13 shows an extremely consistent response selection by all categories toward whether immediate family should be present during the receipt of care. Most felt "no".



How each category of patients surveyed answered question #6, Section II.

FIGURE 14

Figure 14 shows an extremely consistent response selection by all categories of patients to other relatives being present when care is being received. The admissions and outpatient categories were identical in their response selections. By far again, the most preferred choice was "no".

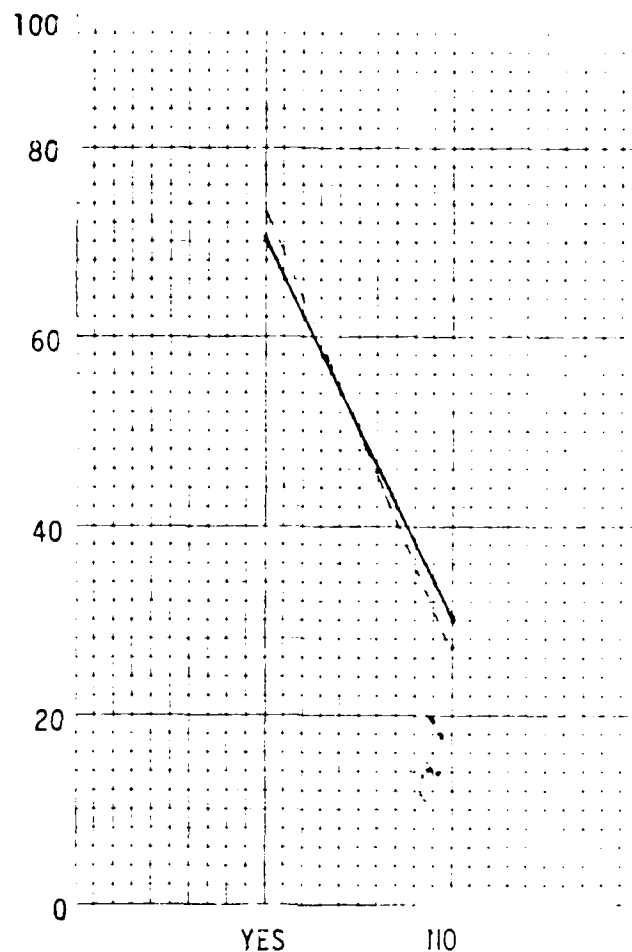


How each category of patients surveyed answered question #6, Section III.

FIGURE 15

Figure 15 shows an extremely consistent selection response by all categories of patients to whether friends should be present when medical care is being received. Admissions, outpatient, and inpatients responses were identical. Even more pronounced than before was the response "no".

Percentage

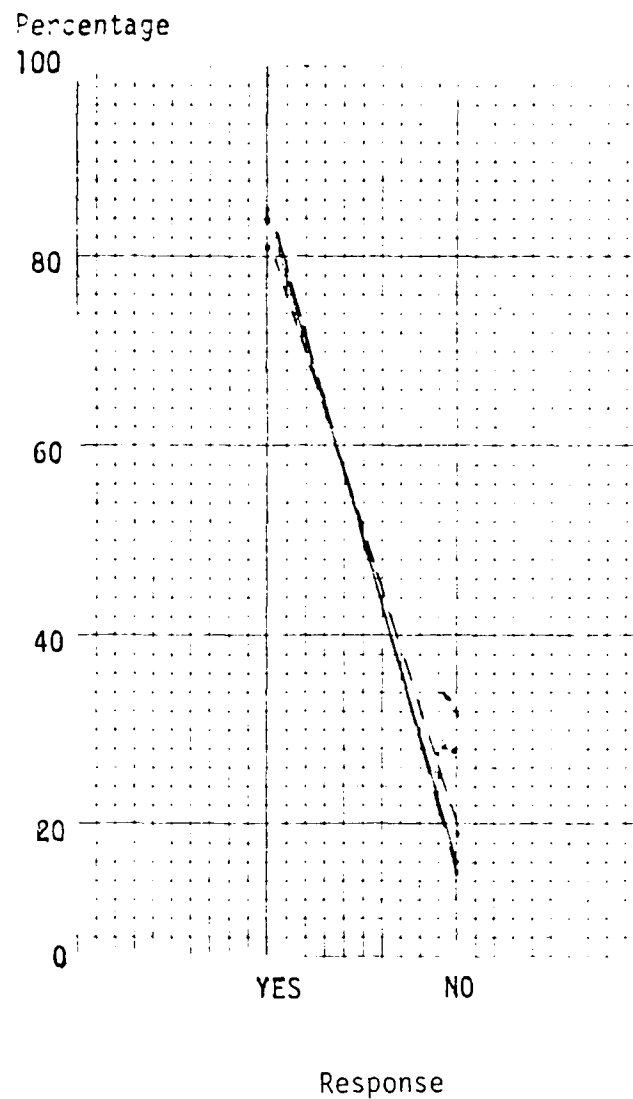


Response

How each category of patients surveyed answered question #7, Section I.

FIGURE 16

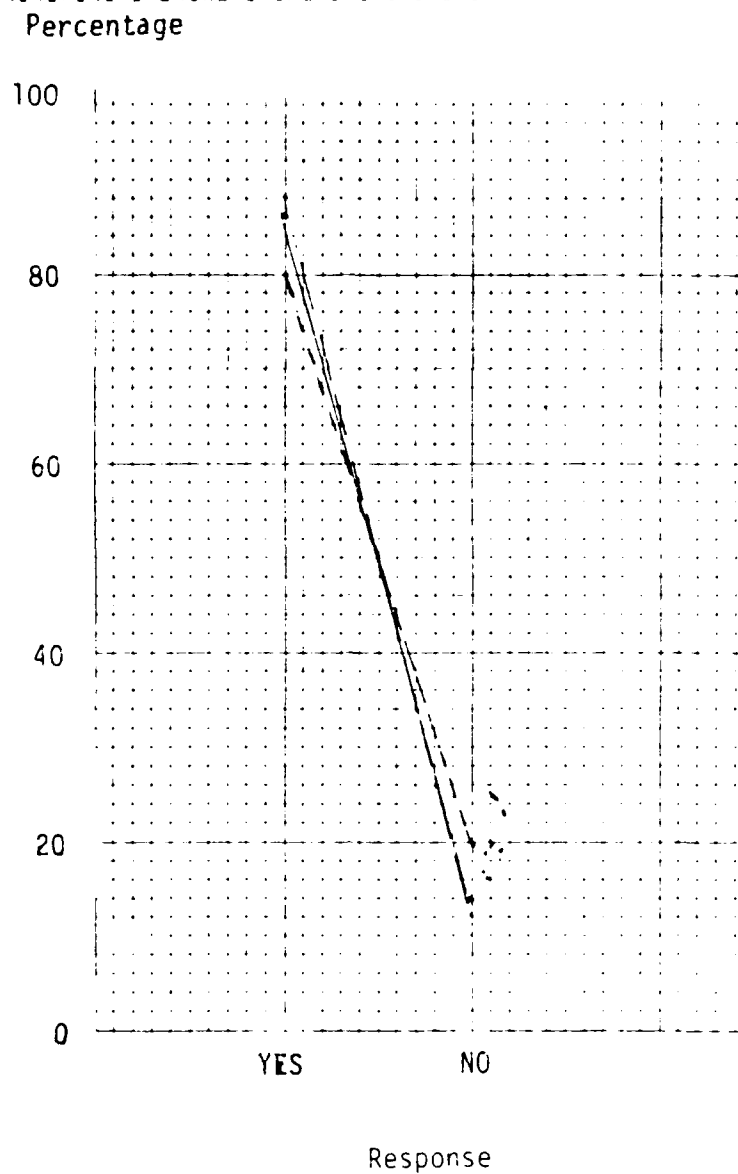
Figure 16 shows an extremely consistent response selection rate by all categories to a patient having some time free from being visited by their immediate family members. Figures 17 and 18 depict responses for other relatives and friends to the same question. In each case the most preferred choice was "yes", with the "yes" response being more pronounced, as you proceed from immediate to the friends category.



How each category of patients surveyed answered question #7, Section II.

FIGURE 17

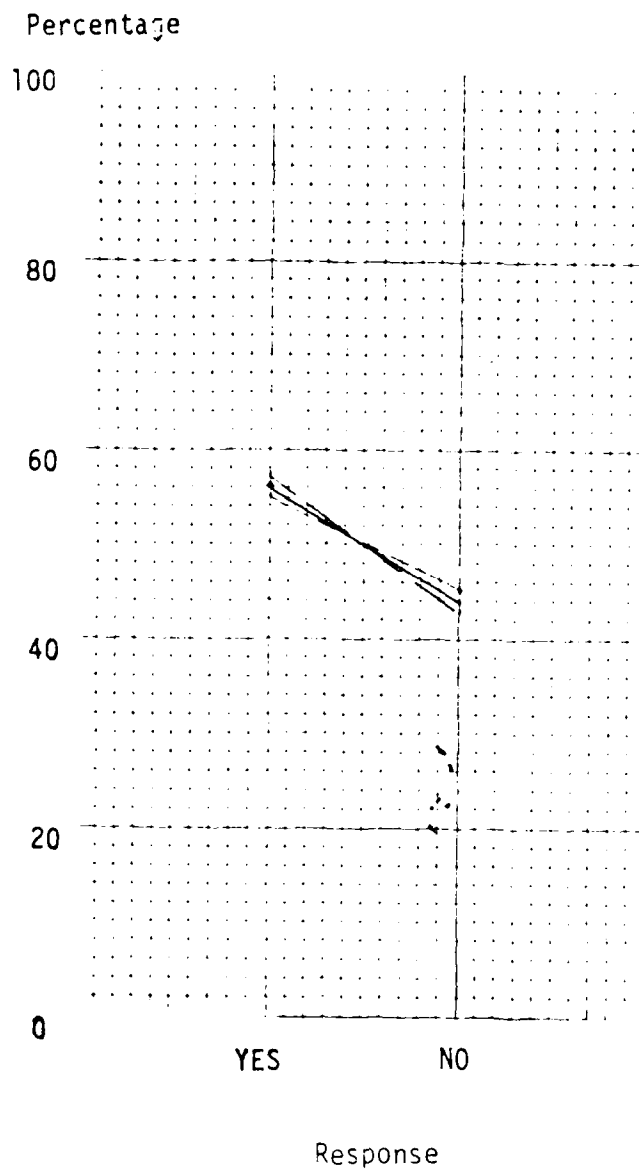
See comment at figure 16.



How each category of patients surveyed answered question #7, Section III.

FIGURE 18

See comment at figure 16.

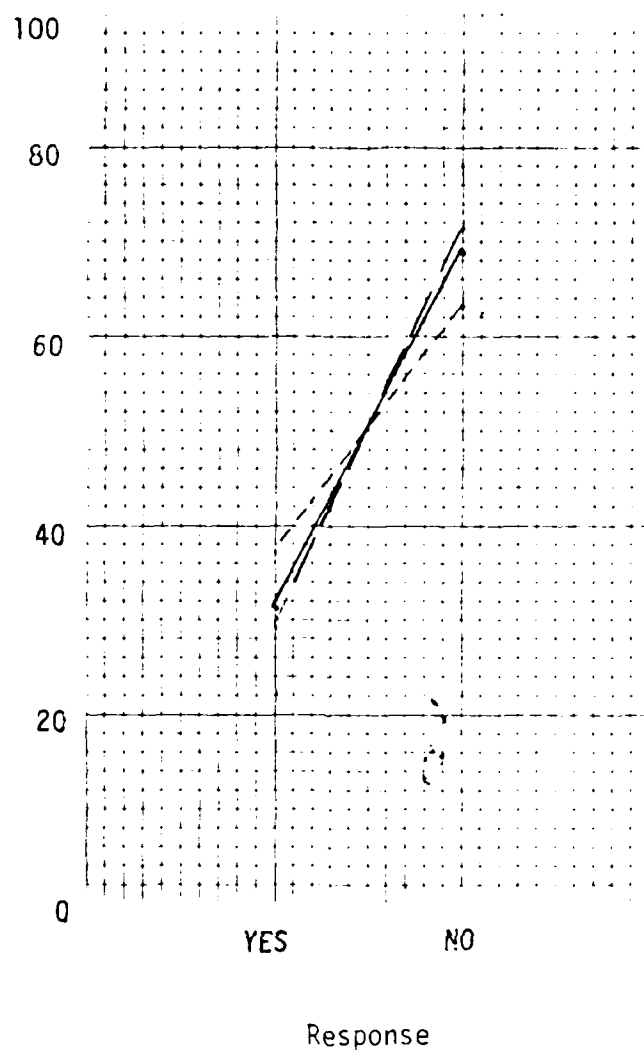


How each category of patient surveyed answered question #8, Section I.

FIGURE 19

Figure 19 depicts a consistent response selection by all categories surveyed, to whether children of the immediate family should be allowed to visit regardless of age. The most preferred choice was "yes".

Percentage

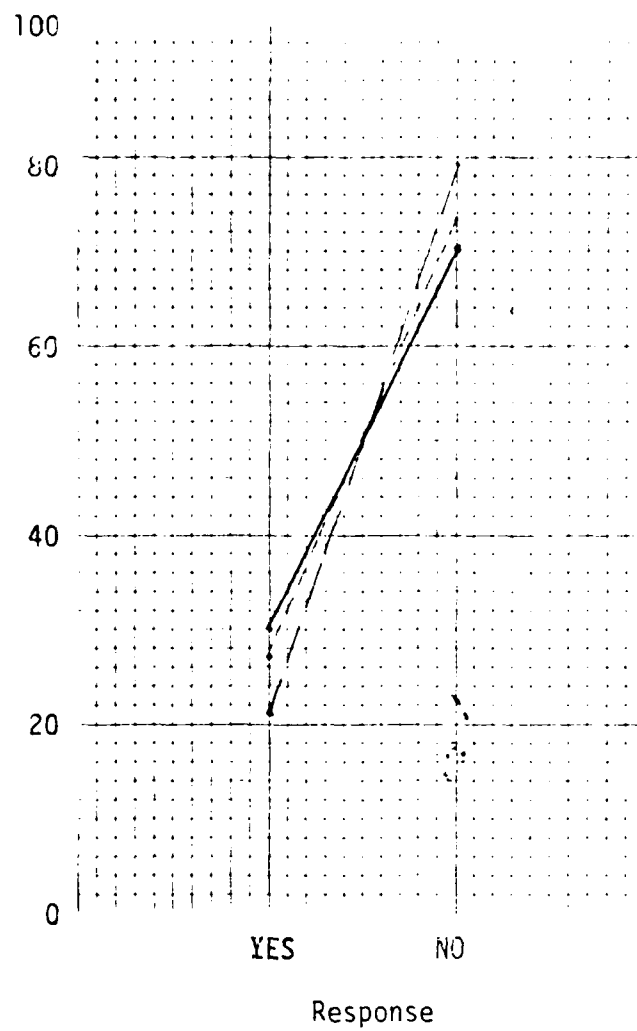


How each category of patient surveyed answered question #8, Section II.

FIGURE 20

Figure 20 shows a consistent response selection by all categories to the question of children visiting regardless of age. The most preferred choice was "no", as applied to children of other relatives, in difference to the result reported in figure 19. These same results are found in figure 21, but on a more pronounced scale toward the "no" response, as applied to children visiting of close friends.

Percentage



How each category of patient surveyed answered question #8, Section III.

FIGURE 21

See comment on figure 20.

APPENDIX E

Graphs Depicting Vertical Analysis

These graphs provide a vertical analysis of the matrix. The following legend applies.

_____ = Immediate Family Member Visitor

_____ = Other Relatives Visitor

----- = Friends Visitor

Percentage

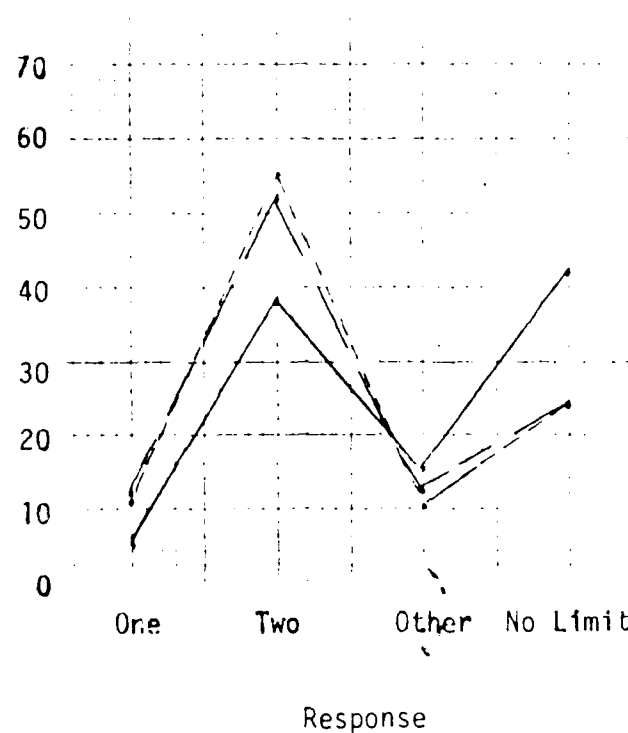


How the admissions category of patients surveyed answered Question #1 in each section.

FIGURE 22

Figure 22 shows the responses by the admissions category of patients toward how many of each category of visitors should be allowed at any one time. The most preferred response was two for every category, with the immediate family having the highest percentage of "no limit" selections.

Percentage

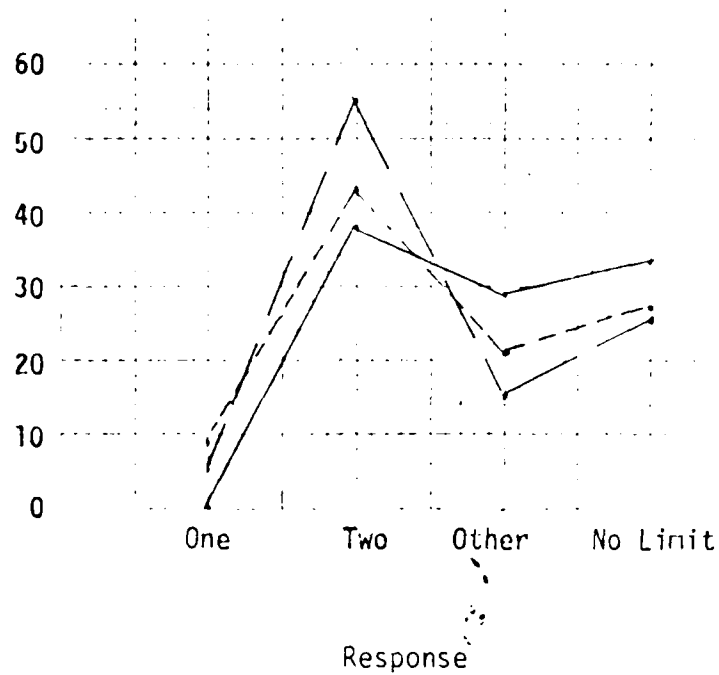


How the outpatient category of patients surveyed answered Question #1 in each section.

FIGURE 23

Figure 23 shows the responses by the outpatient category of patients toward how many of each category of visitor should be allowed at any one time. The most preferred response was two, with the immediate family receiving the highest selection rate for the "no limit" choice.

Percentage

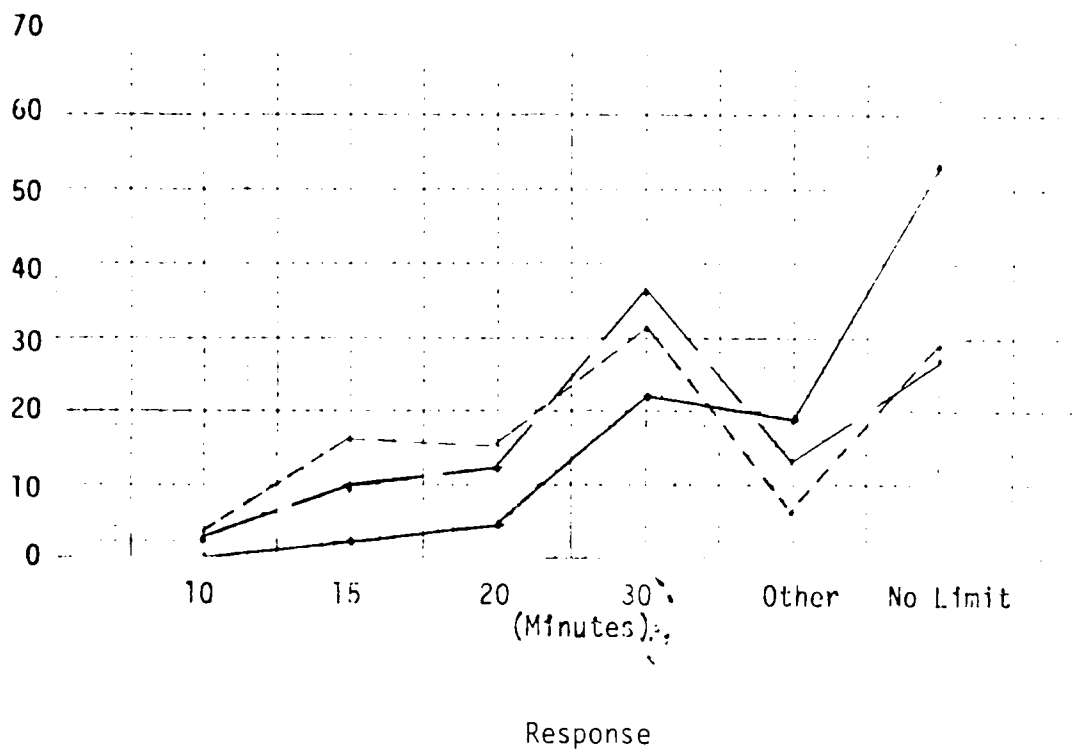


How the inpatient category of patients surveyed answered Question #1 in each section.

FIGURE 24

Figure 24 shows the responses by the inpatient category of patients toward how many of each category should be allowed to visit at any one time. The most preferred choice was two, with the immediate family receiving the most "no limit" response selection.

Percentage

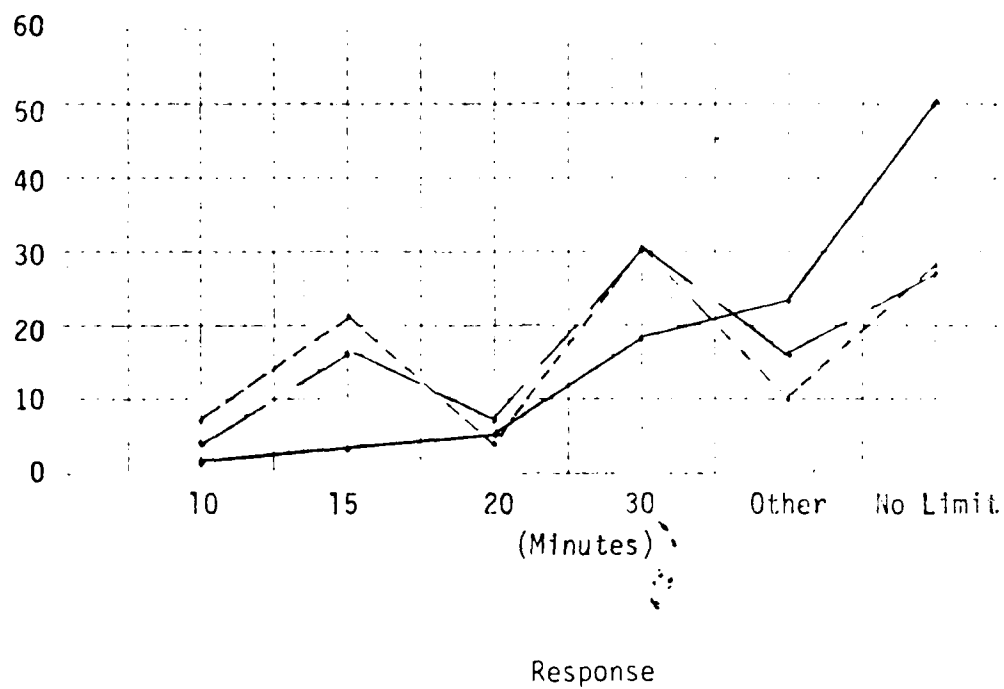


How the admissions category of patients surveyed question #2 in each section.

FIGURE 25

Figure 25 shows the response selections by the admissions category of patients toward each category of visitor regarding the length of time people should be allowed to visit. The most preferred response pertaining to the immediate family was "no limit", with the other category of visitors being limited to 30 minutes of visiting time. Figure 26 provides an identical analysis of the responses of outpatients toward each visitor category.

Percentage

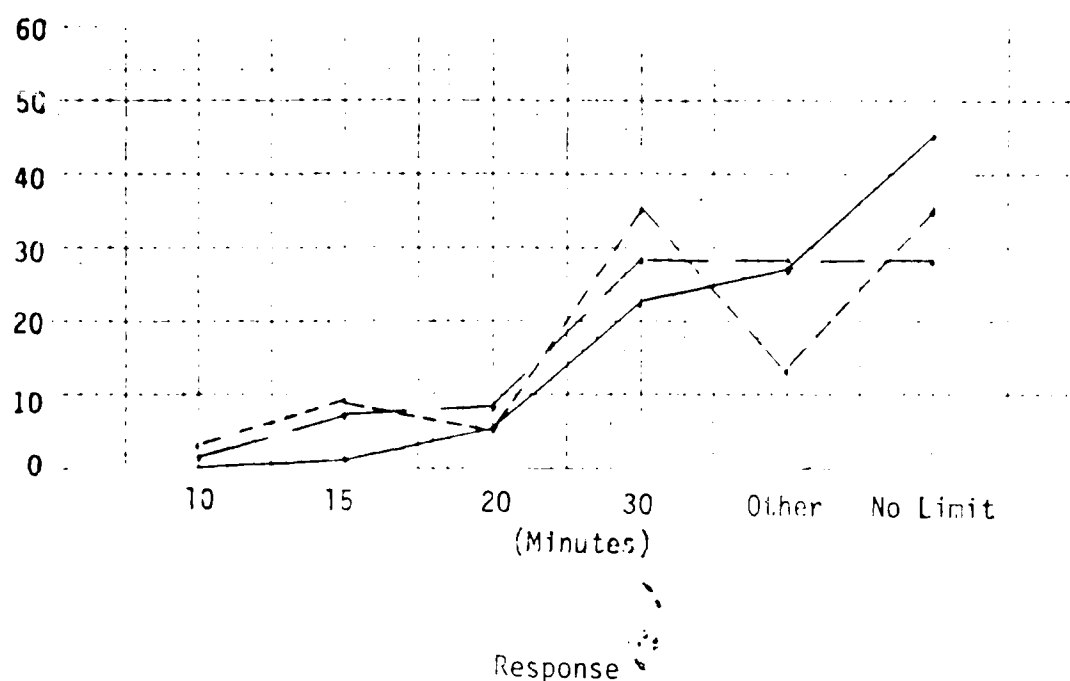


How the outpatient category of patients surveyed answered question #2 in each section.

FIGURE 26

See comments at figure 25.

Percentage

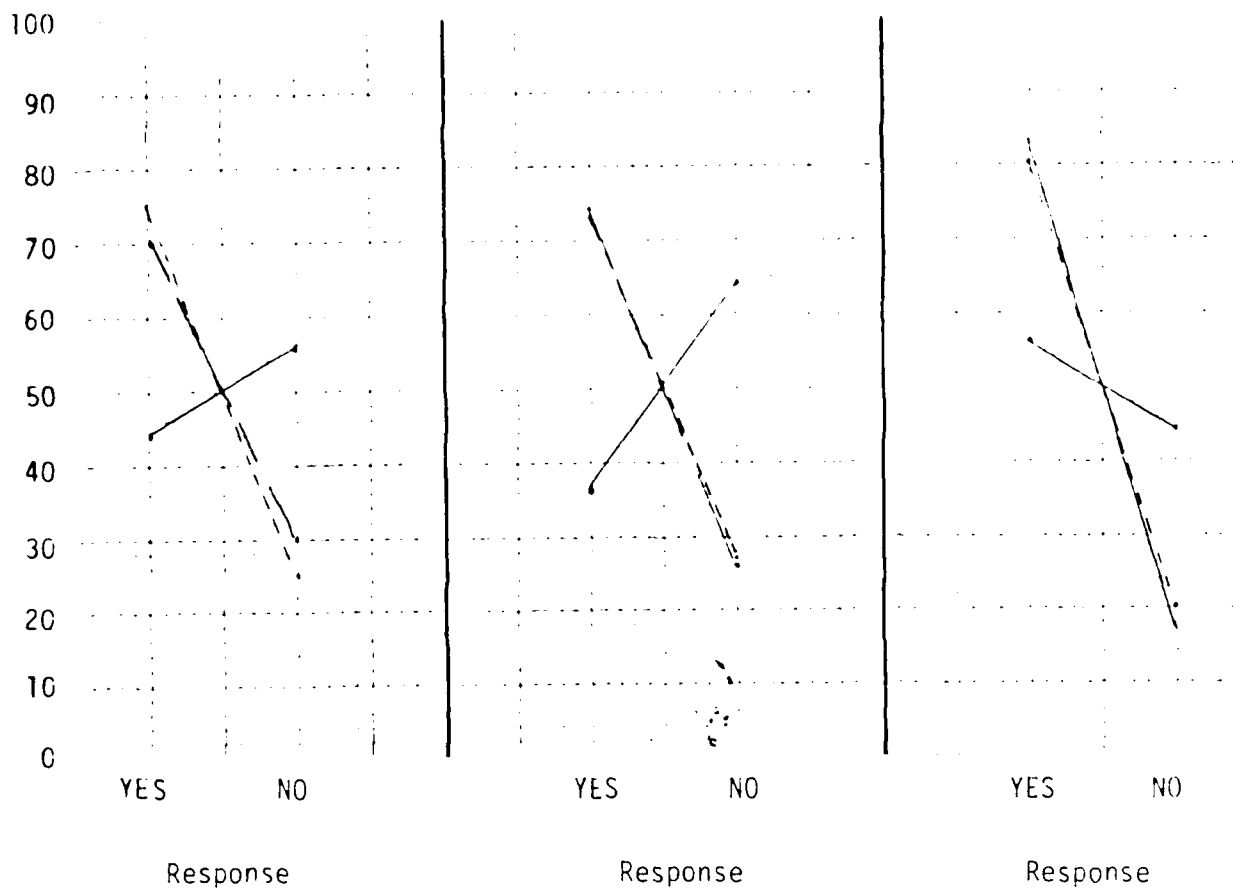


How the inpatient category of patients surveyed answered question #2 in each section.

FIGURE 27

Figure 27 shows the response selection rate by the inpatient category of patients toward each category of visitor regarding the length of time people should be allowed to visit. For the immediate family and the friends, the most preferred selection rate was "no limit". This selection of "no limit" for the friend category was not expected, however, the choice of "30 minutes" was extremely close to being the preferred choice. Other relatives had equal responses for the fourth, fifth, and six choices as the most preferred.

Percentage



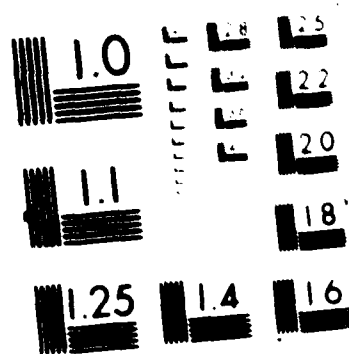
How the admissions, outpatient, and inpatient categories of patients surveyed answered question #3 in each section.

FIGURE 28

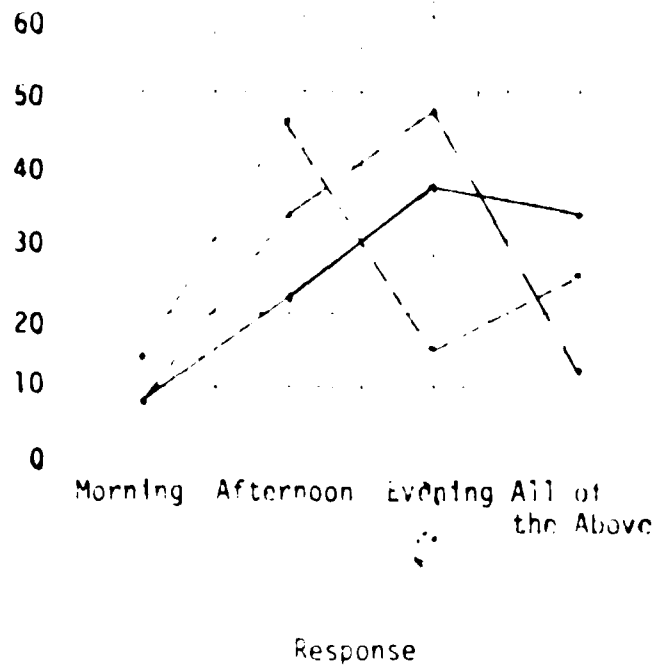
FIGURE 29

FIGURE 30

Figures 28-30 show the response by admissions, outpatients, and inpatient categories respectively of those surveyed regarding set or prescribed visiting hours for each type of visitor. The admissions and outpatients responded with almost identical answers. They felt that there should be no prescribed hours for the immediate family, but restricted visiting was recommended for the other visitors. The inpatients felt that restricted visiting should be in effect for all.



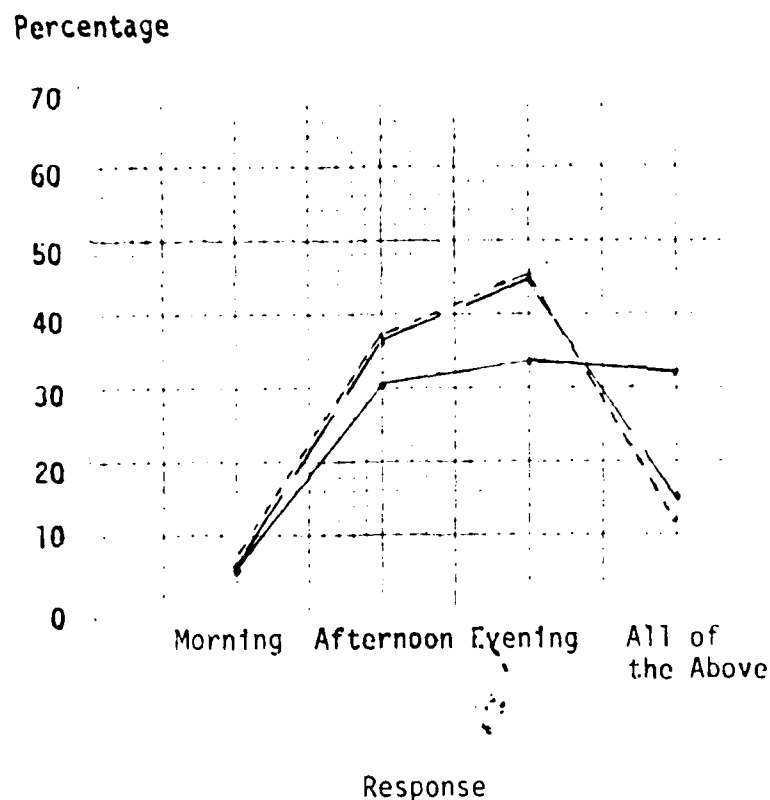
Percentage



How the admissions category of patients surveyed answered question #4 in each section.

FIGURE 31

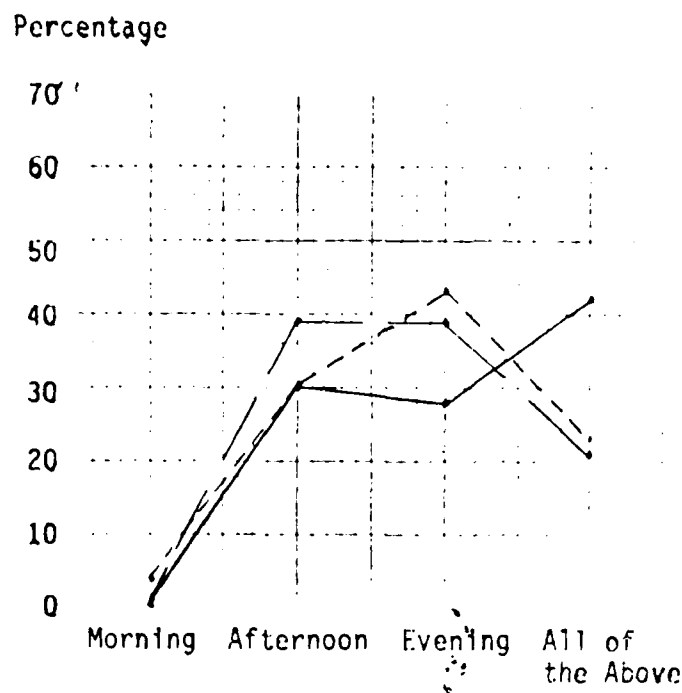
Figure 31 shows the most scattered graph found. The admissions category of patient was responding to the question of, when should each category of visitors visit the hospital. They felt that the immediate family should visit in the evening, as the most preferred choice, but also felt strongly that they would allow them to come all day, as evidenced by the fourth response. Other relatives were restricted to evening hours mostly, with some consideration for response two, or afternoon hours. Friends were restricted to afternoon hours, with interestingly, more consideration given to all day visiting than to evening hours.



How the outpatient category of patients surveyed answered question #4 in each section.

FIGURE 32

Figure 32 shows a more consistent response selection to the same question as in figure 31, but by a different category of patient - the outpatient. Mixed feelings were evident in the immediate family, with response selections 2 - 4 almost identical. It would appear that all day visiting was the most appropriate answer. For other relatives and friends, the outpatients definitely preferred that they visit in the evening, with much consideration for afternoon visiting.

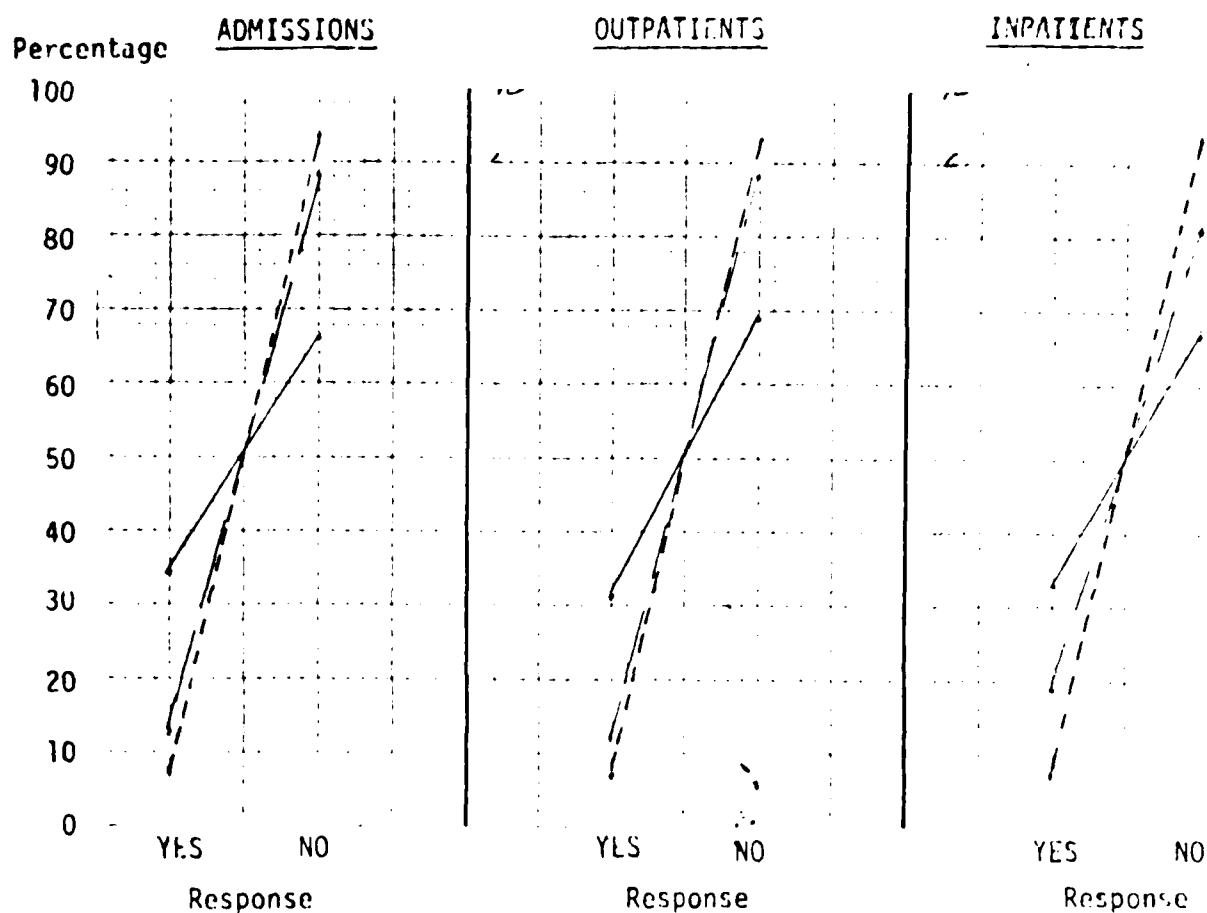


Response

How the inpatient category of patients surveyed answered question #4 in each section.

FIGURE 33

Figure 33 depicts a somewhat inconsistent response by inpatients to whether there should be set or prescribed visiting hours for each category of visitors. The immediate family had a definite vote for all day visiting. The other relatives were split between afternoon and evening hours equally. Friends were restricted to response 3, or evening hours.



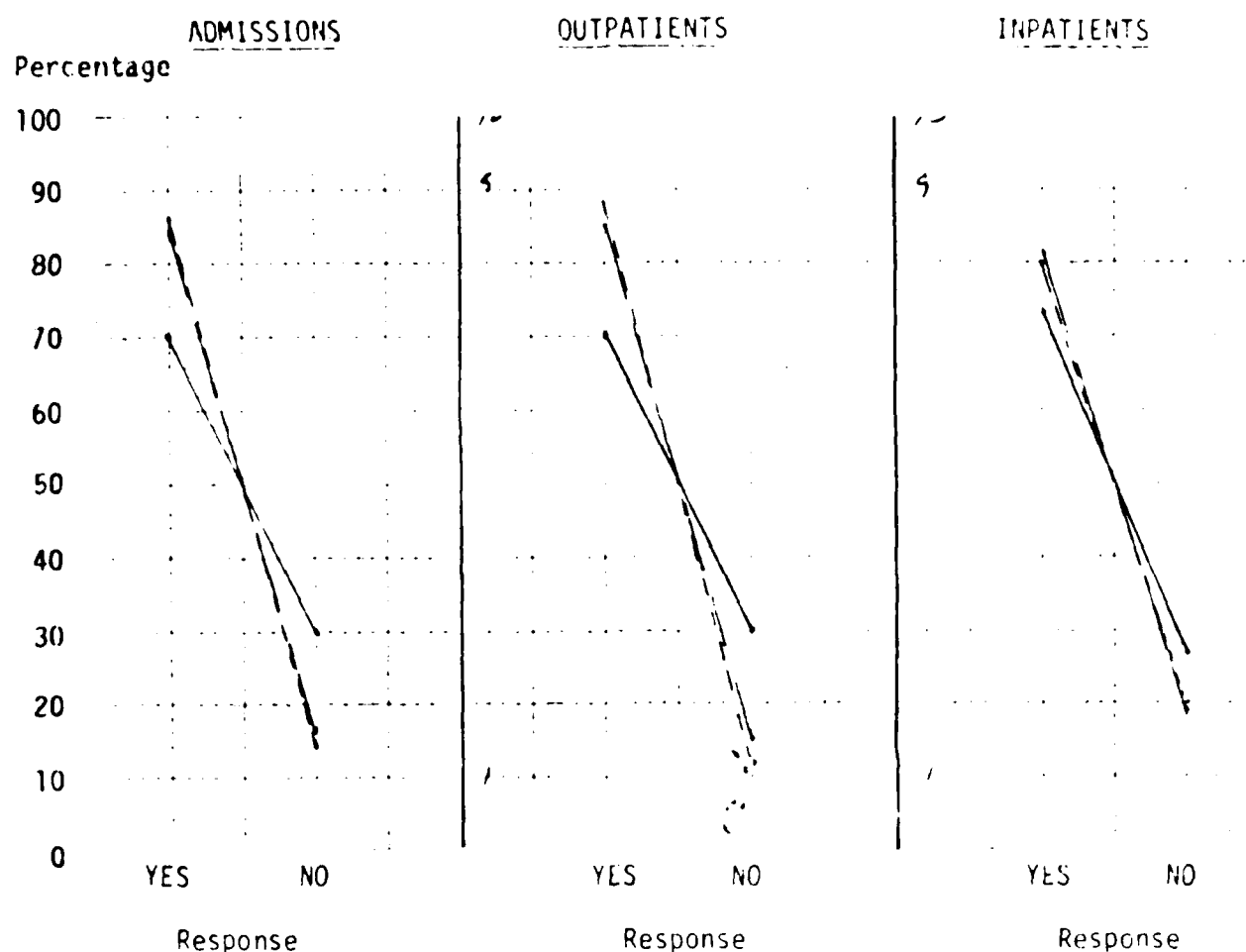
How the admissions, outpatients, and inpatients category of patients surveyed answered question #6 in each section.

FIGURE 34

FIGURE 35

FIGURE 36

Figures 34-36 are for all practical purposes, identical. Admissions, outpatients, and inpatients all felt that no one, regardless of visitor category, should be present when medical care is being received. The response is progressively stronger toward the "no" as you move from immediate family to the friend visitor.



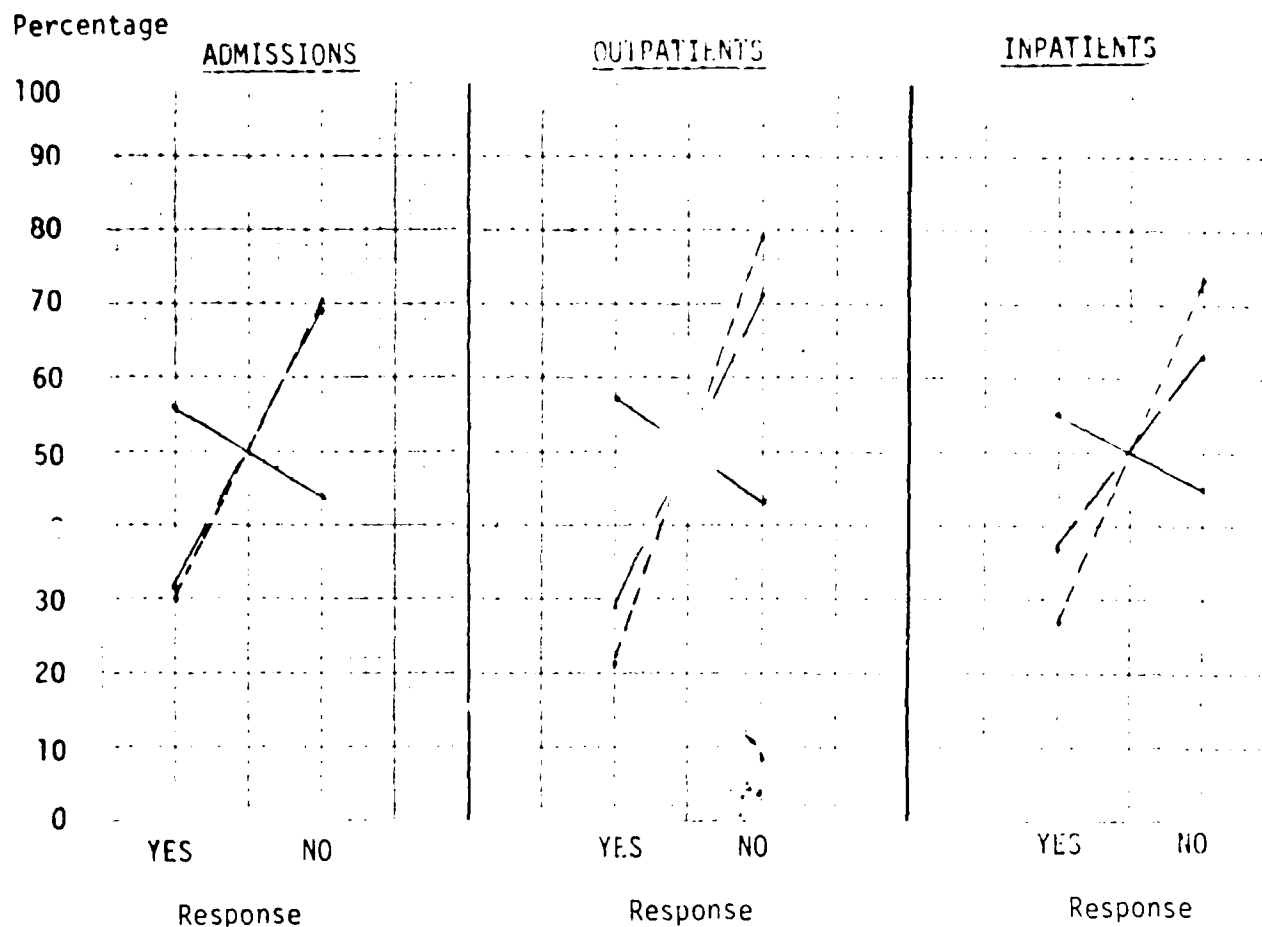
How the admissions, outpatients, and inpatients category of patients surveyed answered question #7 in each section.

FIGURE 37

FIGURE 38

FIGURE 39

Figures 37-39 are, as the three previous graphs, almost identical. Each category of patients felt that they should have some time during the day free from the visitor of any category. The stronger response moves, as would be expected, from the immediate family toward the friend.



How the admissions, outpatients and inpatients category of patients surveyed answered question #8 in each section.

FIGURE 40

FIGURE 41

FIGURE 42

Figures 40-42 are very consistent responses by each category of patient to whether children of each type of visitor should be allowed to visit regardless of age. In each case, children of the immediate family were not restricted as to age. The children of other relatives and friends were restricted in each case to some age limit. The age limit mentioned by the respondents were so varied as to arrive at no specific age grouping that should be considered.

APPENDIX F

Badge Design



BADGE #1

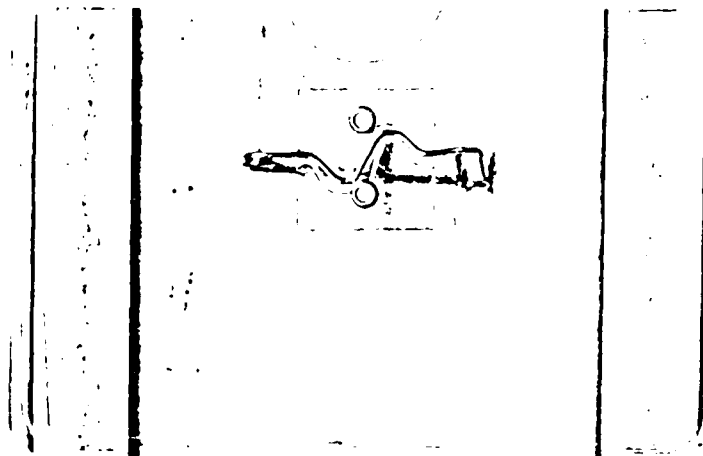
This badge is a round metal type with pin attachment. It was available in many different colors and lettering possibilities. The primary drawback to this badge was the attachment device. The pin was felt to be destructive to visitor's clothing.



BADGE #2

This badge is a laminated plastic folder with a card inserted prior to lamination. It is of identical size and stiffness as the identification card carried by military personnel. The card has a bull dog clip attached to one end to clip on to the clothing of the visitor. No teeth were in the clip attachment to tear clothing. This badge was to be constructed locally by hospital personnel which required buying a laminating machine, and a machine to attach the clip. Spare parts such as clips would be required to be maintained, as well as knowledge

of construction. It would allow flexibility as to design when changes were needed as far as local immediate implementation was concerned. However, response time from a manufacturer was placed at two weeks which negated this as an asset for the locally manufactured badge. Cost analysis did not support this as the best alternative when labor is considered. The fact that the badges have a tendency to "curl" after a while, and wear was considered as against this particular type.



BADGE #3

This badge is a clear plastic pouch with a pin clip attachment. The badge is stiffer than the other plastic badge considered, and should not wear or curl with any degree of significance. The pin clip was objected to the same as the pin on the round metal badge, for destruction of visitor clothing. The pouch would allow for easy changing of the contents, but would also allow visitors to remove them as well.



Name _____

Date _____ Room No. _____

THANKS FOR NOT SMOKING



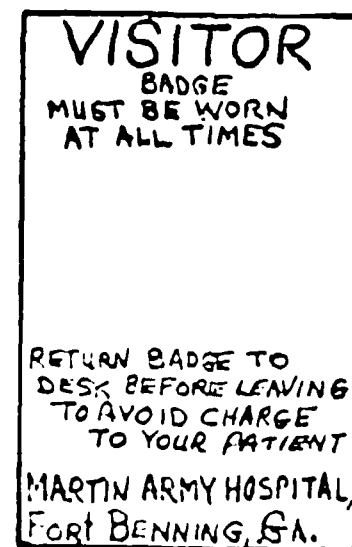
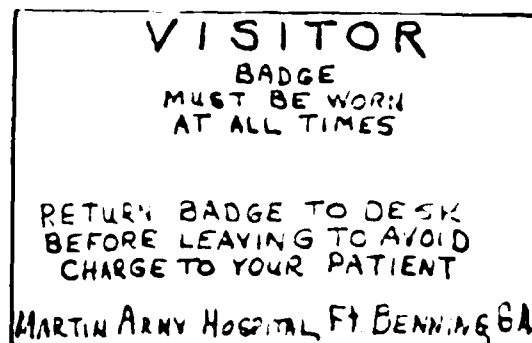
Name _____

Date _____ Room No. _____

THANKS FOR NOT SMOKING

BADGE #4

These badges were found to be the least expensive initially, but considering they were only used once and destroyed, the cost was deceiving. Some people surveyed objected to the use of the sticky substance on their clothes. This sticky substance had a history, from personal use, of shortly losing its power, and the badges fall off. Several colors were available. This type of badge required someone to write the information on the badge, which was considered as a negative point to its use.



BADGE 5a

BADGE 5b

As a result of badges 1-4, the above design was selected. They are basically a combination of badges 1-4. The badge is circular and will have a bull dog clip the same as badge 2 although not shown. The design of badge 2 was preferred over all other designs as far as size and clip attachment, which resulted in badge 5a above being the preferred choice of those surveyed. The blank space in the badge will be for the actual bed number to be placed. The leaving of this area blank allows flexibility of placing whatever bed number is needed in the space rather than ordering two or three of each bed number for the loss rate anticipated.

APPENDIX G
STORAGE RACK DESIGN FOR VISITOR BADGES

STORAGE RACK FOR VISITOR BADGES

[illegible]

APPENDIX H
Information Desk Redesign

SECTION I - REQUEST (Forward in duplicate)

10. TO: FACILITIES ENGINEER	11. DATE 7 Nov 77	12. REQUESTING ID NUMBER 1340-78
--------------------------------	----------------------	-------------------------------------

3. The following services are requested and are considered necessary. (Describe work in detail and attach sketch if additional clarity is needed; list building number.)

Site of Work: Information Desk Area, 1st Floor, Bldg 9200.

Request the above area be modified according to the diagram and notes attached to this Job Order Request.

The objectives to be realized thru completion of this minor construction project are:

a. Expansion of the Administrative area available to the Admission & Disposition Section will relieve existing overcrowding and provide for a more efficient work area.

b. Newly designed configuration of reception window (Hospital Information Desk) will allow the hospital to implement a visitation control policy. The MEDAC Commander has expressed considerable support for this project. Request necessary cost estimate and design work for this project be scheduled at the earliest possible convenience.

4. NAME OF PERSON TO CALL FOR ADDITIONAL INFORMATION CHARLES L. MCGERRY CPT, MSC	5. ORGANIZATION Logistics Div. MAN	6. TELEPHONE NUMBER 544-3632
7. NAME OF REQUESTOR HINTON G. PAUL LTC, MSC	8. ORGANIZATION Logistics Division	9. TELEPHONE NUMBER 544-4159
10. SIGNATURE OF REQUESTOR		

SECTION II - RECOMMENDATION (Forward original.)

10. TO: (Approving Authority)	11. DATE 23 Nov 77	12. FACILITY ENGINEER IDO
13. SHORT JOB DESCRIPTION Renovable	14. ACTIVITY CODE NUMBER	
15. ESTIMATED COST 6700 Modified		16. RECOMMENDED ACTION a. <input type="checkbox"/> APPROVAL b. <input type="checkbox"/> DISAPPROVED
17. REMARKS Est provided as requested and will be completed when space is available		18. SIGNATURE OF FACILITIES ENGINEER CPO

SECTION III - APPROVAL ACTION (Note on original and return to Facilities Engineer)

10. TO: FACILITIES ENGINEER	20. DATE	21. ACTION a. <input type="checkbox"/> APPROVED b. <input type="checkbox"/> DISAPPROVED
22. REMARKS		23. SIGNATURE OF APPROVING AUTHORITY

SECTION IV - NOTIFICATION OF ACTION

10. TO: (Requesting Officer)	24. DATE
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DA FORM 2701
1 MAY 75

101

REPLACES DA FORM 2701, 1 MAY 75, WHICH WILL BE USED.
WGPO-1975-665-423/1060

MODIFICATION STATEMENT

1. WHEN WORK REQUIREMENT BECAME KNOWN: 7 Nov 77
2. Requested completion date for work: 7 Jan 78
3. Consequences if completion date not met: Expansion of the
Administrative area available to the Admission & Disposition Section will
relieve existing overcrowding and provide for a more efficient work area.
Newly designed configuration of reception window (Hospital Info Desk)
will allow the hospital to implement a visitation control policy. The
MEDDAC Commander has expressed considerable support for this project.


CHARLES L. MCGARRY
CPT, MSC
Chief, Service Br.

1. Glass must meet standards for construction in this state.
2. Reception windows = 2 each. Basic design is shown in sketch provided for Hospital OB - GYN "PRIVACY WINDOW" see drawing number FI-1743 dtd 8 Apr 77.
3. Construction should be from floor to ceiling with bottom 4 feet solid construction (ie wood) and top half or remainder wire glass.
4. Counter for servicing should be approximately 2 ft wide. One foot on each side of wall.
5. Work Area (desk like top) for receptionist should be approximately 2'6" wide extending to wall going under the extended top counter.
6. Electrical outlets (115 Volt) = 8 each, 2 on each side as illustrated.
7. All electronic equipment - paging/communicating - must be moved to new receptionist desk location.
8. Carpet now located behind existing info desk needs to be removed.
9. Address/determine needed ventilation requirements created by new administrative area.
10. Provide nine phone outlets as shown on diagram.
11. The ~~two~~ 115 volt common duty electrical outlets supporting the information reception desk will need to be on EMERGENCY POWER.
12. The door requested on diagram should have a wired glass vision panel and door lock should be keyed to existing hospital SARGENT LE PATTERN keying info available thru SERVICE 3R, MAH 544-3632.

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CLERK

STATISTICS

EXIT X

EXIT X

(10 P.W. AREA)

(CURRENT INFO DESK TO BE REMOVED)

2350

2350

VISITOR GAZE STORAGE PASS

SUPPORT ROOM

EXIT

EXIT

EXIT

EXIT

MAIN LOBBY

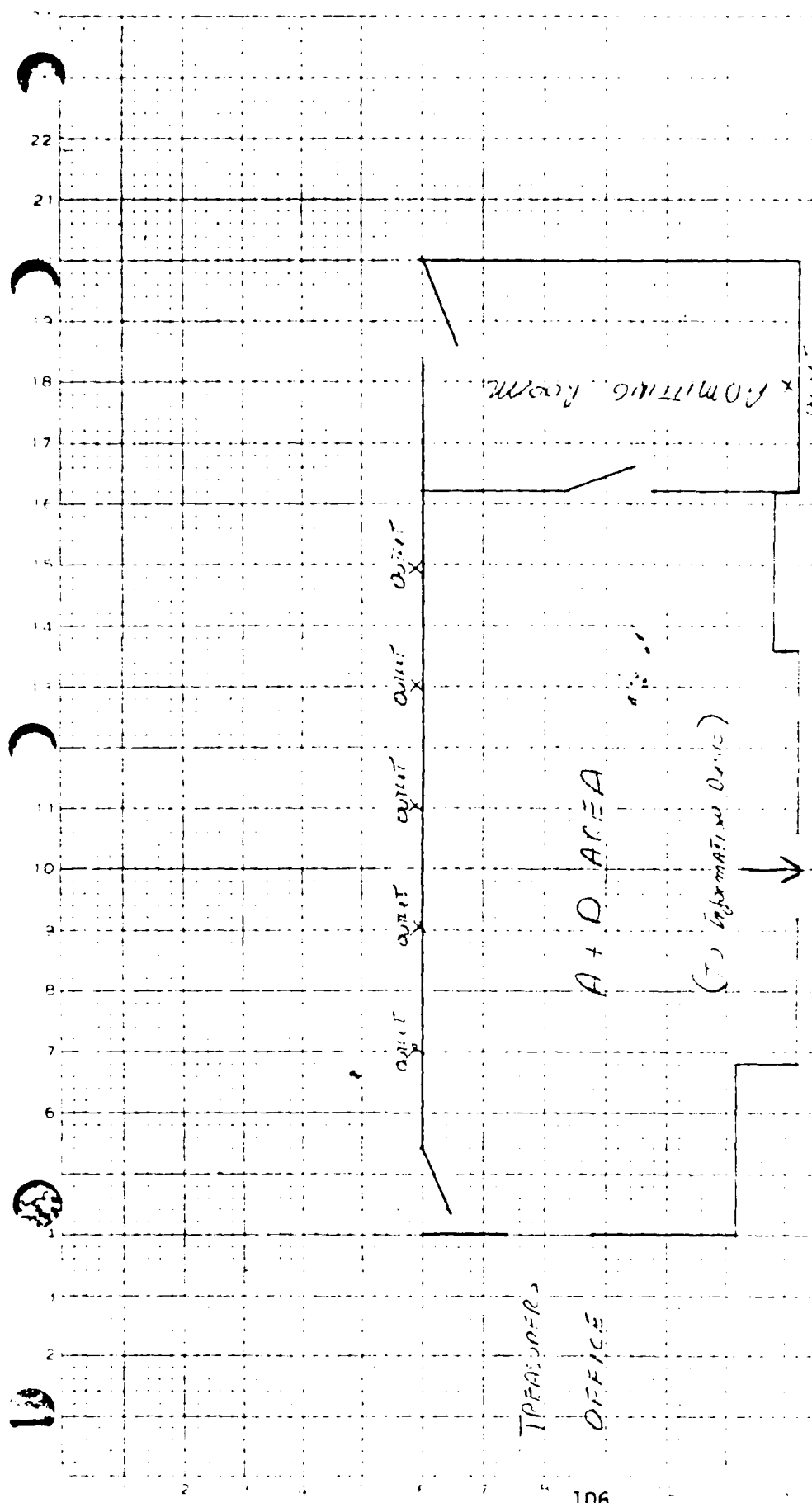
INFORMATION WINDOW

TO TELEPHONE TO PATIENT FLUKE

Δ = Telephone Outlet
X = Electrical Outlet

NOTES - DIAGRAM B

1. Glass must meet standard for construction in hospitals.
2. Two doors leading to corridor should have wire glass vision panel and be equipped with SARGENT door lock and Keyed the same as door lock being install in info/reception area. Door within expanded A&D area should also have a vision panel and be equipped only with a PASSAGE type door hardware.
3. Walls should be wood or other substance from the floor to about 4 feet with the remainder being glass. Existing partial wall should be used.
4. Address/determine ventilation requirements created by expanded Administrative area.



X = FLOOR PLAN

APPENDIX 4

Information Clerk Job Description

JOB DESCRIPTION

Supervisory Controls

Under general supervision, receives assignments in accordance with daily workflow. Instructions are given on new or revised methods, policies, and unusual problems. Work is reviewed for overall results, the rendering of efficient and satisfactory services, and in terms of tact, diplomacy, and courtesy extended in dealing and communicating with patients, staff personnel, and outsiders.

Major Duties

1. Serves as receptionist in the main lobby of the MEDDAC complex. The complex encompasses Martin Army Hospital with numerous staff offices, clinics, wards, various medical services (Radiology, Pathology) and other offices and buildings physically located in remote areas from the main hospital building such as the Hospital Annex with clinics, pharmacy, Preventive Medicine, etc.; Veterinary Activity; Dental Activity with widely dispersed clinics; Troop Medical Clinics. Answers a wide variety of inquiries using a comprehensive knowledge of the overall organizational structure and functions in order to provide appropriate information; directs patients to appropriate clinics and services to include specific guidance when buildings are physically located in remote areas. In order to accomplish the above, incumbent is required to apply a comprehensive knowledge of numerous hospital policies and procedures, such as hours of operation of various clinics and services; appointment system; information which can or cannot be given out; action to take under emergent conditions (mass casualties, fire, patient activity on wards); paging procedure (visual or beeper); Family Practice concept procedure; recognizing situations requiring AOD and/or SDO; procedure to be followed in case of notification of patients being placed on seriously ill, very seriously ill list or in case of death. In order to accomplish the above, incumbent maintains a variety of rosters, card files, ready reference phone directory, duty locations, and is required to act promptly and effectively in order to preclude complaints and to recognize unusual circumstances and report same to supervisor for necessary action.

2. Performs visitor control functions. Incumbent controls access to the inpatient wards of the facility by the issuing of a visitor control pass which authorizes access to certain areas dependent on pass issued. Must be knowledgeable of visiting regulations, patient locations and admissions procedures.

APPENDIX J
LEAD INFORMATION RECEPTION JOB DESCRIPTION

JOB DESCRIPTION

Supervisory Controls

Receives general supervision from Supervisor, A & D Section, who: (1) provides written and oral instructions on normal or revised policies and procedures; (2) is available during portions of the day shift to provide guidance or assistance concerning problems/requirements not covered by established procedures. Requires an incumbent to work independently when supervisor is engaged in work outside the immediate work area; and (3) evaluates work for adequacy and efficiency in rendering service dealing with patients/employers/other staff personnel, and adherence to established policies and procedures of the section.

Major Duties

Serves as working leader of 5-6 Information Desk Receptionists in the A & D Section.

1. Assures that work assignments are carried out by: Distributes and balances the workload among employees in accordance with work flow and specialization procedures established by supervisor. Assures timely accomplishment of assigned workload. Assures that workers have sufficient work to keep them busy. Makes adjustments to workload based on status and progress in accordance with established priorities; obtains needed assistance from the supervisor on problems that arise, such as backlogs which cannot be disposed of promptly. Maintains records relative to work accomplishments. Instructs employees in specific tasks and job

techniques. Provides on-the-job training to new employees as in accordance with established procedures and practices. Maintains a current knowledge of regulatory requirements and answers questions of other employees on procedures, policies, directives, etc. and obtains needed information or decisions from supervisor on problems that come up. Approves leave for a few hours or for emergencies. Resolves simple informal complaints of employees and refers others to supervisor. Reports to supervisor on performance, progress, and training needs of employees, and on disciplinary problems. Makes informal suggestions to supervisor as requested concerning promotions, reassignment, recognition of outstanding performance and personnel needs.

2. Obtains data for reports, studies and projects. Renders such data into narrative/statistical formats which can be utilized to identify problem areas in which operational improvements could be realized. Based upon continuing review and analysis of work unit data, makes recommendations as to operational changes or new programs which would enhance productivity, efficiency and effectiveness with the Section.
3. Performs same duties as group led.

APPENDIX
INTERSERVICE SUPPORT AGREEMENT

ATTACHMENT II

HOST AND TENANT RESPONSIBILITIES

CATEGORY OF SUPPORT

(A1) Police Protection

1. Crime Prevention and Law Enforcement

INSTALLATION/HOST WILL

Provide the following dedicated military police support to MEDDAC to carry out HSC and MEDDAC crime prevention and law enforcement policies and regulations.

a) Hospital coverage by military police personnel to ensure the physical security of personnel and property within the Medical treatment facilities. An MP will be on duty in the area of the hospital ER and will also make military police reports as required in connection with patients. An MP will be on duty daily from 1600 to 0800 hours in the area of the hospital emergency room in order to monitor medical incidents which may have criminal implications.

b) During peak traffic hours an MP will be posted at the major intersections around the hospital to facilitate the flow of traffic to and away from the hospital.

c) The Military Police will participate in the mass casualty plan and exercises, providing traffic control and security for the patient triage area.

d) The Military Police will provide the MEDDAC Commander with timely notification of incidents occurring within his geographic area of responsibility.

USAF MEDDAC/TENANT WILL

Provide copies of HSC and MEDDAC regulations and policies to installation provost marshal. Designate an officer of this MEDDAC as responsible for provost marshal functions within the MEDDAC and for close and continuing liaison with the installation provost marshal for military police support. Responsible for MEDDAC crime prevention and law enforcement program.

CATEGORY OF SUPPORT

2. Physical Security and Crime Prevention

INSTALLATION/HOST WILL

Provide physical security surveys and inspections of critical and sensitive areas of MEDDAC in accordance with physical security standards established by ARs and HSC regulations. Provide security equipment to MEDDAC pending availability of funds.

USAMEDDAC/TENANT WILL

Coordinate MEDDAC Physical Security Plan (HSC Reg 190-1) with installation provost marshal and provide the installation provost marshal a list of critical and sensitive area at the MEDDAC requiring physical security surveys and inspections; determines requirements for physical security equipment and devices utilized at MEDDAC. Responsible for visitor access at MEDDAC in coordination with installation provost marshal, to include appropriate visitor identification and for promptly reporting losses to the installation provost marshal.

3. Law Enforcement Reports

Provide a separate law enforcement and discipline report (DA Form 2819) concerning MEDDAC personnel to Commander, HSC (ATTN: HS-PM), as required IAW Paragraph 2-2d, AR 190-46.

Responsible for promptly reporting crimes and offenses at MEDDAC to the installation provost marshal.

4. SIR Reports

PM, USAIC, will report any incidents of a serious nature involving MEDDAC personnel to the MEDDAC Commander in a timely manner. When the submission of a serious incident report (SIR) is required, the Provost Marshal will be responsible for providing an information copy to Commander, HSC (ATTN: HS-PM).

The MEDDAC Commander will be responsible for reporting (PCs AGI-114(min)) those incidents of a nature which, in his opinion, are serious in accordance with AR 190-40 and will provide information copies of such reports to the provost marshal USAIC.

CATEGORY OF SUPPORT

5. Crime Prevention and
Law Enforcement

INSTALLATION/HOST WILL

Insure qualified guards are provided for those
military prisoners hospitalized at MEDDAC.

Coordinate installation Crime Prevention Plan
(AR 190-31) with MEDDAC Commander.

USAMEDDAC/TENANT WILL

MEDDAC will provide sick call
and emergency care for personnel
confined in the stockade.
MEDDAC will conduct health inspec-
tions as outlined in applica-
ble USAIC Regulations (USAIC
Reg 40-50).

Coordinate MEDDAC Crime Preven-
tion (AR 190-31) with the in-
stallation provost marshal.
Promote an active crime preven-
tion program within MEDDAC to
insure awareness of personnel
of steps individual can take to
reduce crimes. Requesting phy-
sical security equipment and
devices maintaining continuing
liaison with the host installa-
tion provost marshal, and re-
porting all criminal incidents
and property losses to the
host installation provost mar-
shal.

Provide other military police support to MEDDAC
to include absentee apprehension control/regula-
tion of motor vehicles traffic, enforcement of
no parking areas in fire lanes and around oxygen
storage, and military police investigations, on
the same basis as provided other units and ac-
tivities located on the installation. HSC crime
prevention policies will apply within MEDDAC.

CATEGORY OF SUPPORT

INSTALLATION/HOST WILL

Reports of civilian or military personnel (arrest, confinements, etc.) will be forwarded to the MEDDAC Commander for appropriate action without direction of reply as to action taken by the MEDDAC Commander or suspense date.

6. Blood Alcohol Test

Military personnel brought to Martin Army Hospital who require a blood alcohol test will first be informed of their rights under article 31, UCMJ by the apprehending MP. After a blood alcohol sample is obtained, it will be transported along with FM Med Form 327 by the MP to the laboratory.

USAMEDDAC/TENANT WILL

Reports of civilian or military action against MEDDAC personnel will be forwarded to MEDDAC Commander for appropriate action and written response of such action(s) when required IAW Appendix A, AR 190-45.

The Commander of MEDDAC will establish the shortest possible chain of custody on all evidence taken to include blood alcohol samples and evidence secured from possible assault victims. MEDDAC ER personnel will initiate FM Med Form 327 to establish a chain of custody. All parties in the chain of custody will properly sign for custody of evidence.

7. Parking Facilities
Survey and Motor Vehicle
Traffic Supervision

The installation will provide route MP Patrols through MEDDAC parking areas.

Posting of signs to encourage the locking of cars will be assigned and accomplished by MEDDAC. All assigned and attached personnel will be instructed to lock their parked vehicles and to keep valuable items locked out of sight.

CATEGORY OF SUPPORT

8. Traffic Control
Devices

INSTALLATION/TENANT WILL

The installation provost marshal will approve the installation of traffic control devices to assure conformity with the Manual on Uniform Traffic Control Devices for streets and highways; and need as determined by traffic engineering surveys, local traffic direction and control studies and the installation traffic plan.

USAMEDDAC/TENANT WILL

The MEDDAC provost marshal will approve the installation of traffic control devices, to assure conformity with objectives of the Ambulatory Patient Care Program.

The MEDDAC Commander will be responsible for the control and approval of individual reserved parking spaces at MEDDAC facilities. Not more than 10% of the total available parking spaces will be reserved for designated individuals.

9. Vehicle
Registration

The installation will be responsible for providing for the registration of vehicles, belonging to both military and civilian personnel assigned to MEDDAC.

114

MEDDAC will be responsible for following the appropriate installation regulations and directives in regard to vehicle registration. Additionally, MEDDAC will be responsible for its internal registration program.

10. Physical Security
for Controlled Substances

Installation provost marshal will be responsible for providing the physical advice, guidance and physical security for the support in installing the MEDDAC controlled substances program. At his physical security responsibilities, military police will respond to authorized requests initiated by installation and address detainee requests initiated with storage areas for controlled substances. Areas for support will include physical security, vault (Basement of MEDDAC) and supply.

The MEDDAC Commander will insure that controlled substances are properly safeguarded.

CATEGORY OF SUBJECT

THOMAS J. WILLIAMS

- (1) 330, Inpatient Pharmacy
- (2) 330, Outpatient Pharmacy
- (3) Pharmacy Supply Room
- (4) 330, Pharmacy Vault
- (5) 330, Pharmacy Supply Room

11. Proposed Security
for Classified Information
(PSS 11-11-13)

Be responsible for providing technical advice, guidance and physical security inspection support in accordance with the "Guidance" Committee to carry out his physical security responsibilities.

USARMEDDAC/TENANT WILL

in accordance with applicable
Army and HSC Regulations

The MFOAC Commander will insure that classified items are properly safeguarded in accordance with applicable Army Regulations and HSC Regulations.

ATTACHMENT III

Continuation of Space II (DD Form 1144)

All support being provided under terms of this agreement will be on a non-reimbursable basis.

APPENDIX L
VISITOR CONTROL SIGN FOR ENTRANCES

N O T I C E

If you are here to visit a patient, you must enter through the main entrance only and obtain a visitor identification badge. Failure to do so will result in your being asked to leave the hospital. Help us protect the patient you are here to visit.

NOTE: Sign to be placed at the entrance to the ER and main lobby and new clinic wing entrances on a stand that can be placed in the direct path of arriving personnel.

APPENDIX M
VISITOR CONTROL SIGN FOR EXITING HOSPITAL

N O T I C E

All visitors must leave by the main entrance only. Visitors must turn in their identification badge to the information clerk personnel. Other visitors may be waiting to use your badge.

NOTE: These signs should be on stands that can be placed in the direct path of visitor traffic. Specifically at the elevator on the 1st floor, the ER, main and new clinic wing exists.

APPENDIX N

BED LOCATIONS

THESE ARE THE ONLY TWO CASES OF THIS TYPE OF
RECORDS IN THE ENTIRE COLLECTION. THE OTHERS
ARE ALL OF THE SAME TYPE AND ARE ALL OF THE
SAME TYPE AND ARE ALL OF THE SAME TYPE.

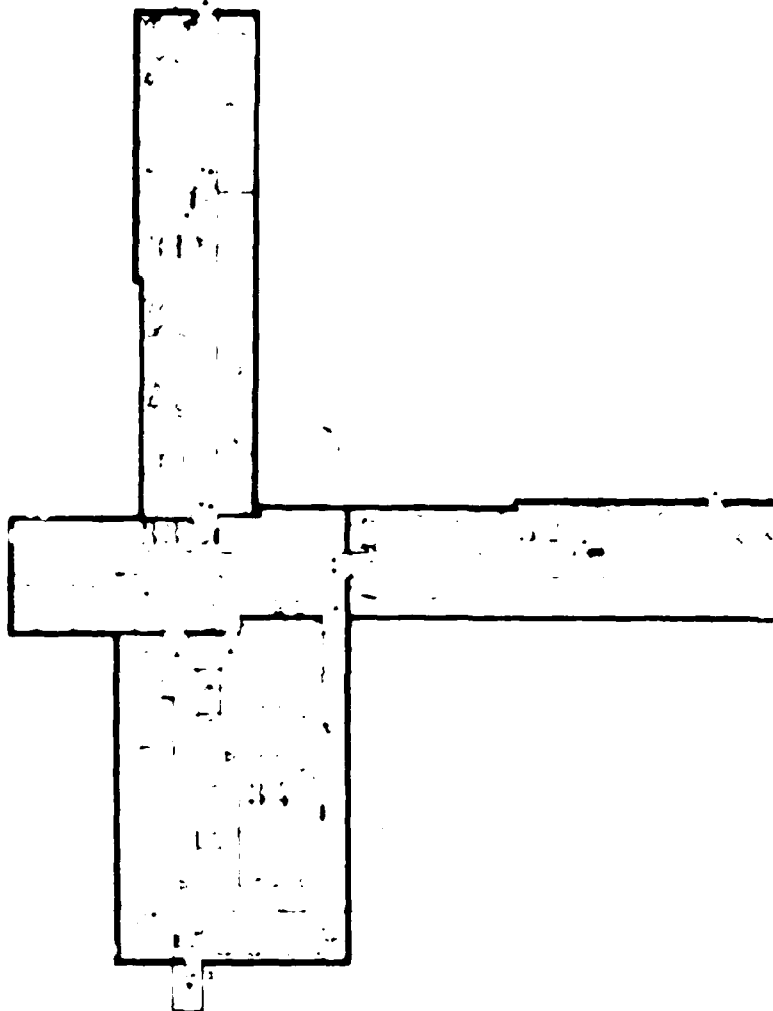


1. The first step is to identify the problem. This involves understanding the current situation and what needs to be changed.

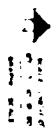
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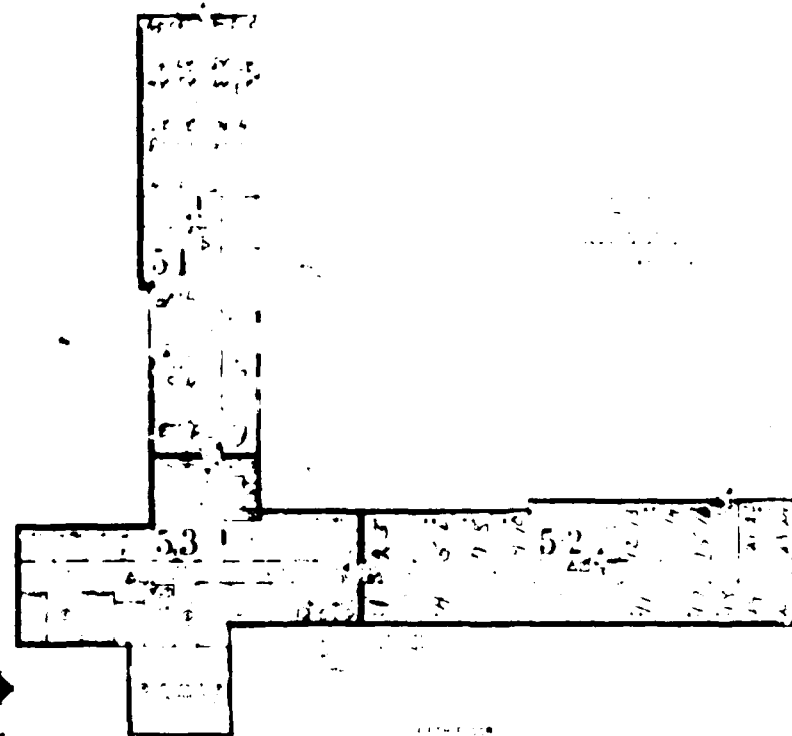
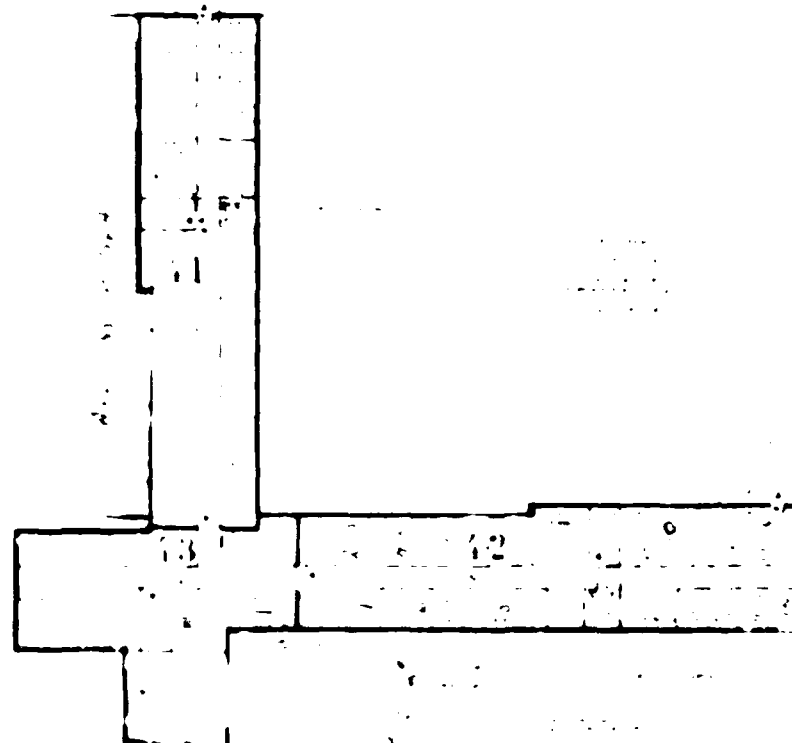
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4. The authors are grateful to the referees for their valuable comments and suggestions.

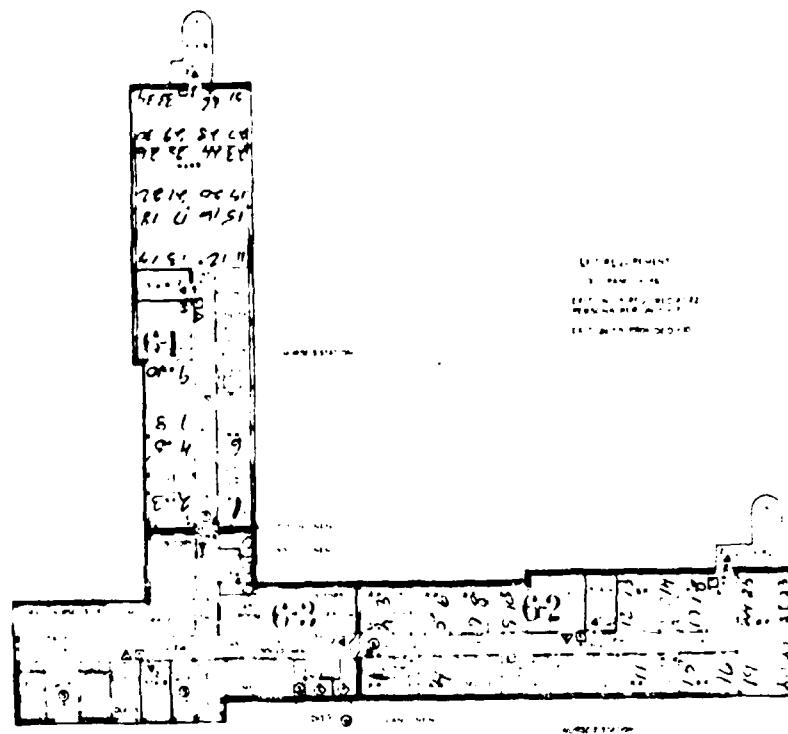


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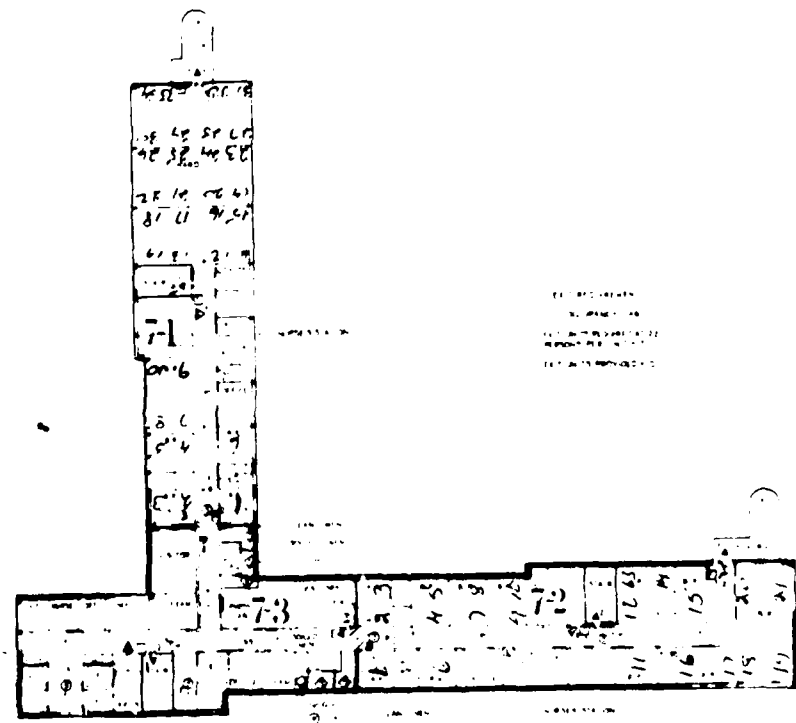




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APPENDIX 'O'

DRAFT VISITOR CONTROL REGULATION

DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Benning, Georgia 31905

MEDDAC REGULATION
NUMBER 40-44

5 April 1978

Medical Service
VISITING AND VISITING HOURS

1. Purpose: To establish a visitor control and visiting policy for Martin Army Hospital.

2. Definitions:

a. Visitor: Any individual entering Martin Army Hospital not employed by the facility or whose name does not exist in the Table of Distribution and Allowances of the Medical Activity, or the Dental Activity, not entering for the purpose of conducting official business.

(1) Outpatient visitor: Any individual entering Martin Army Hospital for the purpose of receiving medical care, treatment, or advice on an outpatient basis. (Not to be controlled under this regulation.)

(2) Inpatient visitor: Any individual entering Martin Army Hospital for the purpose of receiving medical care, treatment, or advice on an inpatient basis. (Not to be controlled under this regulation.)

(3) Patient visitor: Any individual entering Martin Army Hospital for the purpose of visiting an inpatient of that facility.

b. Official visitor: Any individual entering Martin Army Hospital for the purpose of conducting the official business of the Department of the Army, State, Federal, and military organizations and to their official capacity.

c. Staff: Any individual military or civilian employed by Martin Army Hospital or whose name appears in the Table of Distribution and Allowances of the Medical Activity, or the Dental Activity, who arrive for the purpose of conducting official business.

d. Visitor control: Any action taken to restrict the number of visitors within the facility, any action taken that restricts access to the facility to visitors, and any action taken that places time limits on the presence of visitors to the facility.

e. Immediate family: Immediate family includes husband, wife, son, daughter, parent, or grandparent.

e. Other Relative: Any relative not listed above such as aunt, uncle, cousin, brother-in-law and sister-in-law.

f. Friend: Those visitors having no status as a relative of the patient.

g. Children of Immediate Family: This is limited to children or grandchildren of the patient. If the patient is a son or daughter, the children of the immediate family is limited to their brothers and sisters.

h. Child: For the purpose of this regulation, the age of 14 applies. Any child 14 and older may visit without an adult accompanying them.

3. General:

a. Visitors are authorized to visit as per the visiting hours and instructions stated for each ward below. Visitors not conducting themselves in an appropriate manner, or who violate the rules for visitors as set forth in this regulation, or who act in violation of physician or nurse orders (patient specified) may be removed from the hospital. Patients who desire to visit with their visitor at a location other than on the ward must coordinate with the ward personnel.

b. There will be no more than two visitors at any time with any one patient unless a special visitor's badge has been issued. Each visitor will be required to obtain and wear a visiting pass. All hospital employees are responsible for directing unauthorized visitors to use the proper entrance, obtain and wear a pass and confine their visits to the area for which their pass is issued.

c. Seriously Ill/Very Seriously Ill Patient: These patient's visitors and visiting rules are specifically excluded from those presented below for each ward. All visitors to these patients will wear a special visitor's badge. Their rules are as follows:

(1) Visiting may be permitted at any time during the day or night, if the physician concurs. This applies only to the immediate family.

(2) Children of the immediate family will be allowed to visit regardless of age unless excluded by the physician. Children are not permitted to visit without an adult accompanying them.

(3) Visiting by other than immediate family is restricted to general visiting hours of 1400 to 2000 hours.

(4) Visitors must report to the information desk upon arrival and each time they depart to receive and turn-in their special badge.

5 April 1978

(5) Should these SI/VSI patients have no immediate family, the special visiting privileges may be extended at the physician's discretion to the other relatives and friends.

(6) Visitors to SI and VSI patients are authorized to eat their meal in the hospital but must pay the appropriate amount. The visitor must go to the Adjutant's office and obtain a meal pass. Then the visitor should proceed to the dining facility and pay for the meal. Once the visitor has gone through the serving line, they may eat in the facility or carry their tray back to the patient's room. The special visitor's badge is their authority to leave the dining facility with their tray. The tray may be returned to the facility along with the trays from the ward. This applies to the immediate family only.

d. Pediatric Ward: The pediatric patient because of their age is of special interest to the hospital. Many times the visitor can be of immeasurable assistance to hospital staff. The rules are as follows:

(1) Visiting by the immediate family may be permitted at any time of the day or night unless excluded by the physician.

(2) Other relatives and friends are restricted to the general visiting hours of 1400-2000 hours daily.

(3) Children of the immediate family will be allowed to visit regardless of age unless excluded by the physician. Children are not permitted to visit without an adult accompanying them.

(4) The visitor to the pediatric ward will wear the normal color badge for that area.

(5) Unlimited visiting hour privileges may be extended to the other relative and friend should no immediate family be available.

(6) One member of the immediate family is authorized to eat their meals in the hospital so long as the appropriate amount is paid. The visitor must go to the Adjutant's office and obtain a meal pass. Then the visitor should proceed to the dining facility and pay for the meal. Once the visitor has gone through the serving line, they may eat in the dining facility or carry their tray back to the patient's room. The visitor's badge is their authority to carry the tray from the dining facility. The tray may be returned along with the trays from the ward.

e. Psychiatric Ward:

(1) Visiting by the immediate family may be permitted at any time of the day or night unless excluded by the physician.

(2) Other relatives and friends are restricted to the general visiting hours of 1400-2000 hours daily.

(3) The visitor to the psychiatric ward will wear the normal color badge for that area.

(4) Unlimited visiting privileges may be extended to the other relative and friend should no immediate family be available.

(5) Children of the immediate family may visit regardless of age unless excluded by the physician. Children are not permitted to visit without an adult accompanying them.

f. Obstetrical Ward:

(1) Visiting by the immediate family may be permitted at any time of the day or night unless excluded by the physician.

(2) Other relatives and friends are restricted to the general visiting hours of 1400-2000 hours daily.

(3) Visitors to the obstetrical ward must wear the normal color badge for that area.

(4) Unlimited visiting privileges may be extended to the other relative or friend should no immediate family be available.

(5) All visitors must wear gowns and scrub before visiting the patient.

(6) Children of the immediate family may be allowed to visit regardless of age. Children may not visit unless accompanied by an adult.

g. Recovery Ward: For patients expected to remain in the recovery ward only for the post anesthetic period, visiting will be restricted to the immediate family and only upon the physician's approval. For patients expected to remain for longer than the post anesthetic period, the following applies:

(1) Visiting by the immediate family may be permitted at any time of the day or night unless excluded by the physician.

(2) Children of the immediate family may be allowed to visit regardless of age. Children may not visit unless accompanied by an adult.

(3) Visitors to the recovery ward will wear the normal color badge for that area.

(4) Other relatives and friends are restricted to normal visiting hours of 1400-2000 hours daily.

(5) Other relatives and friends may be extended unlimited visiting privileges if no immediate family are available.

h. Cardiac Care Unit: For those patients on the CCU that are on the SI/VSI list, those rules apply unless modified by the physician. For those patients on CCU not on SI/VSI, the following rules apply:

(1) Visiting by the immediate family may be permitted at any time of the day and night subject to the physician's approval.

(2) Children of the immediate family may visit without regard to age. Children must be accompanied by an adult when visiting.

(3) Other relatives are restricted to normal visiting hours.

(4) Visitors to the CCU will wear the normal color badge for that area.

(5) Other relatives and friends may be extended unlimited visiting privileges if no immediate family are available.

i. Surgical Intensive Care Unit: Paragraph h above applies in its entirety. Read SICU in place of CCU.

j. General Medical and Surgical Wards: For all other patients the following applies:

(1) Visiting by the immediate family may be permitted at any time of the day or night unless excluded by the physician.

(2) Children of the immediate family may visit without regard to age. Children must be accompanied by an adult when visiting.

(3) Other relatives and friends are restricted to normal 1400-2000 hours visiting.

(4) All visitors must wear the normal color badge for that area.

4. Visitor Rules (General):

a. All visitors must enter through the main entrance and obtain the appropriate visitor badge from the information desk.

b. Visitors must wear the badge visible at all times.

c. Visitors may go only to those areas authorized by the color of the badge.

d. Visitors must dress appropriately for visiting the patient. Failure to comply with dress codes will result in removal from the facility.

e. No more than two visitors may visit at one time unless special permission has been granted by the physician or nurse.

f. All gifts and articles carried into the hospital must be cleared through the information desk personnel.

g. Visitors should consider that a 15 minutes visit is long enough. Immediate family visitors may stay longer.

h. Only children of the immediate family are authorized to visit unless special permission is granted by the physician.

i. Visitors must leave when the visiting privileges have been terminated for that day.

5. Visitor Badges: Each floor has been assigned a color as shown below. The badges of the same color will be issued to visitors wishing to visit patients on that floor.

FLOOR 2	WHITE
FLOOR 3	GREEN
FLOOR 4	YELLOW
FLOOR 5	PINK
FLOOR 6	BLUE (LIGHT)
FLOOR 7	SILVER
FLOOR 8	ORANGE
FLOOR 9	BROWN

The special visitor will be issued a red colored badge. The official visitor will be issued a purple colored badge.

6. Restrictions: Physicians may modify any instruction contained in this regulation that they feel appropriate in providing care to their patient. Physicians wishing to modify visiting procedures must provide their instruction on each patient to the information desk personnel.

7. Excluded Persons: Solicitors, peddlers, or persons suspected of carrying liquor or narcotics to patients or personnel on duty in this hospital will not be allowed to enter. Nurses, wardmasters and all hospital employees are to be on the alert for such activities. Should such a person be noticed or should a visitor's conduct in any way be open to question, it will be immediately reported to either the Ward Officer or the Administrative Officer of the Day.

8. Responsibilities:

a. Information desk personnel are responsible for issuing and collecting visitor badges and controlling traffic through the main lobby entrance.

5 April 1978

b. All hospital employees are responsible for enforcing the restrictions imposed by this regulation. Specifically ward personnel are vital in discovering and taking appropriate action on offenders.

c. The AOD and SDNCO will assist information desk personnel and ward personnel as necessary in enforcing the visitor control policy of Martin Army Hospital.

(ATZB-MA)

FOR THE COMMANDER:

IRA F. WALTON III
CPT, MSC
Adjutant

DISTRIBUTION:

A

APPENDIX P
VISITOR BROCHURE

THE

MARTIN

ARMY

HOSPITAL

VISITOR

"A

MEMBER

OF

THE

HEALTH

CARE

TEAM"



Dear Visitor:

Martin Army Hospital is dedicated to providing the best care possible to all of our patients. This is not only the job of the physician but involves the nurse, aide, medical corpsman, housekeeper, clerk, administrative staff, and a host of others. We call it a health care team. Each individual involved plays a vital part and is charged with a tremendous responsibility -- a human life.

Whether you realize it or not, you are a member of the health care team I speak of. You cannot, should not, nor will you be allowed to escape this responsibility if you visit the Martin Army Hospital. If you feel that was a harsh statement, you are right. We do not take visiting lightly, and neither should you.

It has been proven that a good visit to a patient is a good visit to the patient, and hospital length of stay is often reduced because of the attitude and interest of the visitors.

The information that follows is to help you understand how to become a good visitor, and what your responsibilities are as part of the Martin Army Hospital health care team. It is the hope that this information will help you to have a more enjoyable visit to the hospital.

1. Be on time.

2. Be courteous.

3. Be helpful.

4. Be interested in the patient.

5. Be respectful of the staff.

6. Be a good example to the patient.

7. Be a good example to the staff.

ENTERING THE HOSPITAL

There are three primary entrances to the hospital. All are approximately the same distance from the parking lot. One of these entrances is for the emergency room and should only be used for patients to the area. As a visitor, you should enter through only one entrance - the main entrance. It is clearly marked MAIN ENTRANCE and the large flagpole located in the front of the entrance makes it easy to find. The third entrance is the outpatient clinics entrance located in the new wing. It should be used by outpatients seeking care in one of our many clinics.

AFTER VISITING THE HOSPITAL

[illegible]

Also important is that you turn in your badge when you leave. Others may be waiting and until your badge is returned, they cannot get to see the patient.

VISITING RULES

The following provides some specific requirements that you should be aware of. Some of our wards have different rules than others so pay close attention to the rules on the ward where your patient is located.

General:

(1) All visitors must enter through the main entrance and obtain a visitor badge to be worn at all times they are in the hospital.

(2) Only two visitors are permitted to visit at one time unless special exception has been granted by your patient's physician.

(3) Children under the age of 14 are not permitted to visit unless they are members of the immediate family -- husband, wife, son, daughter, parent or grandparent.

(4) Children may not be left in the lobby while you visit your patient. There are nursery facilities on post to assist you.

(5) Normal visiting hours are from 11:00 A.M. to 8:00 P.M. daily, to include weekends and holidays. These hours apply to the patient's friends and all relatives other than the immediate family who desire to visit.

(6) The immediate family of the patient may visit at any time of the day or night unless specifically restricted by the physician or nurse. This is a real privilege and a little common sense will keep it available to you.

(7) Children of the immediate family may visit the patient without restriction, but children under the age of 14 must be accompanied by an adult.

(8) Members of the immediate family of patients who are listed on the Seriously Ill or Very Seriously Ill Report may eat in the hospital dining facility. You must obtain a pass from the Adjutant's Office, pay for your meal in the dining facility, and go through the serving line. We would prefer that you eat your meal there, but if one person in the family feels it necessary, they may carry their tray to the room, and eat their meal with their patient. Please check with the staff first.

(9) One member of the immediate family of pediatric patients who is staying with the patient over the meal period may be authorized to eat in the dining facility at the request of the nurse in charge of the ward. Please follow the same procedures provided in (8) above.

(10) Visitors should keep their visits between 15-30 minutes in length. Others may be waiting.

WHERE CAN YOU VISIT

Obviously the patient's bedside is one good choice but the wards also have a waiting room available and there are two main lobbies, as well as attractive areas on the hospital grounds. PLEASE DO NOT leave the ward area without letting the ward staff know where you are taking your patient.

WHAT COLOR BADGE DO YOU GET

Depending on the floor your patient is on, the following applies:

Floor 2	White	Floor 6	Blue (light)
Floor 3	Green	Floor 7	Silver
Floor 4	Yellow	Floor 8	Orange
Floor 5	Pink	Floor 9	Brown

If you are visiting a patient on the Seriously Ill or Very Seriously Ill Report, or are otherwise identified as a Special Visitor, you will be given a red colored badge. This badge entitles you to some special consideration because of the patient you are visiting.

Official visitors to our hospital, such as local, state, federal, and military officials will receive a purple badge when they are visiting in their official capacity.

A good visitor is --

- (1) One who does not sit on the patient's bed while visiting.
- (2) One who does not smoke while visiting patients.
- (3) One who does not stay forever and allows others to have their turn to visit.
- (4) One who does not pry into the patient's medical condition.
- (5) One who thinks about the items they bring into the hospital and whether they may harm their patient or others.
- (6) One who observes the visiting rules.
- (7) One who does not leave their children unattended in the hospital.
- (8) One who does not disturb others while visiting.
- (9) One who leaves the room while care is being provided to their patient or to others when it is appropriate.
- (10) One who is pleasant and cheerful in conversation with the patient.
- (11) One who does not visit when they are sick.

A Closing Note -- You should have noticed that the rules are quite simple. It really is only good common sense and courtesy. If you are concerned about some aspect of visiting that is not covered here, please ask us. We are flexible and will try our best to meet your needs. In that respect, you should also be aware that the hospital staff may find it necessary from time to time to modify any procedures contained in this brochure. We will always explain our reasons why, and ask for your cooperation in caring for your patient.

Throughout the reference has been to your patient. It is a big responsibility!

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